Self-Harm in a Men's Prison: Staff's and Prisoners' Perspectives

A thesis submitted to Middlesex University in partial fulfilment for the degree of Doctor of Philosophy

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Funded by the Economic and Social Research Council (ESRC)
Studentship Number PTA - 030 - 2003 - 01573

October 2007

Abstract

This thesis draws on feminist and critical phenomenological perspectives to explore the issue of self-harm in men's prisons. In relation to what remains a "hidden problem" (Howard League, 1999, p. 1), the needs of men harming themselves with no apparent suicidal intent have been particularly overlooked, as have those of staff dealing with this complex behaviour. In-depth interviews with 20 adult male prisoners and 38 members of staff explored participants' experiences, views and concerns in relation to repetitive, non-suicidal self-harm. A pluralistic methodological approach, drawing on the principles of thematic and discourse analysis, informed the analysis of interview data, to reveal dominant themes, as well as tensions, inconsistencies and possibilities for change. As shown by previous studies, the notion of non-suicidal self-harm as "attention seeking" was a recurrent theme amongst staff, especially officers, doctors and nurses. This was situated within multiple, and at times overlapping, discourses, including 'medication seeking', 'poor coping' and 'cry for help' themes. In many accounts, less stigmatising discourses also existed, but were applied to specific types of 'self-harmers' (often a minority) in a rigid and hierarchical manner. Interviews with specialists and prisoners challenged this "stereotypical view", re-positioning men who self-harm as 'victims' and/or 'survivors' of their "imported vulnerability" (Liebling, 1995), and of the "pains of imprisonment" (Sykes, 1958). Amongst the latter, difficult relations with staff, and negative reactions to self-harm, were reported to have important implications for prisoners and their self-harming behaviours. Locating these responses within the context of staff's roles and occupational cultures helped to further understand and deconstruct the sorts of reactions that prisoners identified as "dangerous" and dehumanising, and also brought attention to their possible functions and effects for staff themselves. The wider context of work also provided a useful focus to consider how negative staff reactions to self-harm may be addressed. Eliciting staff's views and preferences for training, support and supervision revealed some of the tensions in supporting staff - and prisoners - in an under-resourced and over-crowded environment, and where a 'macho' form of managerialism, and actuarial conceptualisations of 'care', arguably hinder the welfare of both prisoners and staff. The thesis concludes by reflecting on these findings, the ways in which they were produced, and their wider implications for future policy and research.

Acknowledgments

This research would not have been possible without the help and co-operation of many people. I am deeply indebted to the 58 staff and prisoners who generously shared their time, thoughts and experiences for this project. I would also like to express my gratitude to the numerous members of staff who facilitated these interviews, making me feel welcome, safe and at ease, in what can be a very difficult environment. Although they cannot be named to protect participants' anonymity, I owe an especial word of thanks to the establishment's Governing Governor, and members of the Safer Custody Team and Psychology Department.

The NOMS Applied Psychology Group and Safer Custody Group also played an important role in helping me gain access to participants, as well as in overseeing the design and ethics of this study. Thanks are especially due to Tunde Adeniji, Jo Borrill and Jo Paton, for all their time, help and feedback. I also gratefully acknowledge the funding and support of the Economic and Social Research Council, and the additional funds provided by Middlesex University.

Conducting this research would not have been as exciting or rewarding without the excellent supervisory team with which I was blessed. The term 'supervisor' does not even begin to describe the support and guidance I received from Joanna Adler and Karen Ciclitira over the years. Thank you Joanna for encouraging me to embark on this project, and, at every step of the way, pushing me - with confidence - beyond what I thought to be my limits. I am also very grateful to Karen for her constant help and direction, and for introducing me to new, political and exciting ways of 'doing' psychology. The Psychology of Women Section of the British Psychological Society has also been instrumental to this process, and an important source for critical thought, discussion, and friendship. I would particularly like to thank Rose Capdevila and Lisa Lazard, for arguing with me that language is not just language - and much more. Extra special thanks are also due to Eike Adams, Lilliana DelBusso, Nena Foster, Anamika Majumdar and Maria Papadima, for being "in it together" in such a fun, stimulating and supportive way.

Thank you to Brad Blitz and Rosemary Sales for being great friends and colleagues at a particularly difficult time, to Armand D'Angour for his invaluable feedback and advice, and to Sue Berger, Denise Martin, Nicky Payne and Fiona Starr for their encouragement and intellectual input over the years. I would also like to thank my family for their continuing support, and especially my mother for making me smile and take "three deep breaths" whenever I needed to. Thanks also to my brother Davide and auntie Sylvia, for always reminding me that there is more to life than work. I will be forever grateful to Patrick, who has been there from the beginning, with unfailing love and patience - and millions of cups of tea. Finally, I would like to thank my dad, whose wonderful, passionate and critical mind continues to be a great source of inspiration, and I miss every day. *E' a te che dedico questa tesi e questi anni di lavoro, con affetto "cosmico" e sperando che ti compiaccia.*

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Self-Harm in a Men's Prison: Staff and Prisoners' Perspectives

Preface

> [T]here is a clear link between the pain of imprisonment and harm (as self-inflicted injury or suicide) [...] it is crucial that the reality of this pain and its consequences are reflected in research (Liebling, 1995, p. 183).

This thesis draws on a range of theories and disciplines to explore the subject of non-suicidal self-harm amongst adult male prisoners, and the different meanings and implications it may have for both prisoners and staff. Both theoretically and philosophically, this research is located within a diverse literature on the effects of imprisonment (Cohen & Taylor, 1972; Liebling & Maruna, 2005; Sykes, 1958; Toch, 1992a; Zamble & Porporino, 1988). A basic premise of this body of research is that, notwithstanding the alleged "risk" and "vulnerability" (Liebling, 1992) of people in custody (which are in themselves problematic), "the ethos of an establishment, how inmates are treated, will determine the amount of self-injury" (anonymous prison governor, as quoted in HM Chief Inspector of Prisons (HMCIP), 1999, p. 43).

Within this popular framework, self-harm has been conceptualised as a way of coping with the harms and "pains" of imprisonment (Sykes, 1958), and thus constructed as a test of the "health" (HMCIP, 1999), "moral performance" (Liebling & Arnold, 2004) and legitimacy of our prisons and criminal justice system (see also Liebling, Durie, Stiles, & Tait, 2005). Therefore, in focusing on the "hidden problem of self-harm in prisons" (Howard League, 1999, p. 1), my agenda was - and remains - to problematise the contemporary nature, "dominance" (Cavadino & Dignan, 2002) and (over)use of imprisonment.

There are, regrettably, many other indicators of the pains of imprisonment (e.g. fear in prisons, suicides, riots or, arguably, re-offending rates), which could be investigated to this effect. However, I was particularly interested in (non-suicidal) self-harm, partly because I had only recently 'discovered' this behaviour, and felt rather puzzled by it. In addition, I felt sad and shocked to learn how negatively people who self-harm tend to be

perceived and treated in prisons (and not only). Therefore, in researching this topic, my objective was also to increase understanding of self-injury (not least of which my own), and to provide a space for alternative, and less stigmatising discourses and practices.

In the pursuit of originality, I decided to carry out my research with adult male prisoners, whose needs in relation to self-injury have received very little attention in the literature. A small-scale quantitative study conducted as part of my undergraduate degree became a platform on which new ideas and methods were developed. In this first study (Marzano, 2001), structured interviews were carried out with 20 male prisoners with a history of self-harm, and 20 others who had never self-harmed in custody, to investigate the relationship, if any, between participants' styles of communication and self-expression, and self-harming behaviours. The results suggested self-harming prisoners to be somewhat more reluctant to seek social support than prisoners who had never self-harmed. This was interpreted as explaining - at least in part - their greater propensity to resort to self-injury as a (maladaptive) emotional management strategy, or, in the words of Arnold and Magill (1996, p. 35), as "a way in which [to] speak of their pain".

Although the research reported in this thesis has departed quite considerably from this preliminary study, both in focus and methodology, my undergraduate project was useful in bringing attention to the complex and under-researched needs of men who self-harm in custody. At the same time, and consistent with previous research, it pointed to the importance of locating these needs within the context of their relationships with fellow prisoners and staff, as well as with family and friends outside prison.

Whilst all of these areas need and deserve more attention, previous studies suggest that staff's interactions with prisoners may be particularly crucial. Indeed, it is now well-established that "relations between staff and prisoners are at the heart of the whole prison system" (Home Office, 1984, para. 16). As the ones with the most contact with prisoners – and perhaps the most power over them – prison staff hold a key role in the prevention and management of suicide and self-harm in custody (see e.g. Inch, Rowlands, & Soliman, 1995; Liebling & Krarup, 1993; Rowan, 1997). This role, however, is often seemingly compromised by negative staff attitudes towards self-harm, and associated, sometimes poor, practices (see e.g. Liebling, Tait, Durie, Stiles, &

Harvey, 2005). These, in turn, appear to arise "particularly in a context where self-injury is poorly understood, and where staff are not adequately trained or supported" (Howard League, 2003, p. 12). Consistently, there is evidence that training, supporting and supervising staff in dealing with self-harm can contribute to creating a supportive environment for those at risk of suicide and self-harm (see e.g. Burrow, 1992; Liebling & Chipcase, 2001), and generally enhance the regime (Adler, 1999; Liebling, Price, & Elliott, 1999). In addition, helping staff to cope with this complex area of work may benefit workers themselves, and, by potentially reducing staff sickness and turn-over rates (Bailey, McHugh, Chisnall, & Forbes, 2000), have benefits for the National Offender Management Service (NOMS) - the system created in 2004 by merging Probation and Prison Services in England and Wales, "to protect the public and reduce re-offending" (see http://noms.justice.gov.uk).

On this premise, I conducted a postal survey of all HM Prison Service Establishments in England and Wales to gather information about existing sources of support for staff dealing with prisoners who self-harm, and identify positive practice examples (see Marzano, 2004; Marzano & Adler, 2007). This study, carried out as part of an MSc degree, suggested that, even when present, provisions may have not adequately met the needs of staff working with prisoners who self-harm, particularly when dealing with repetitive and non-suicidal self-harming behaviours. On this basis, it was concluded that there is a need to enhance awareness and understanding of the impact of self-harm on prison staff, and to increase knowledge of ways to support staff which are both helpful and practical within the prison context.

The current, doctoral research was developed to address these very aims, and to increase awareness and understanding of self-harm in men's prisons, from the perspectives - and in the words - of staff and prisoners. Of particular interest are a) the welfare and motivations of male prisoners who repeatedly self-harm with no apparent suicidal intent, b) the impact of repetitive, non-suicidal prisoner self-harm on staff, and c) issues around training, support and supervision for staff dealing with this complex issue.

The following chapters explicate these research aims in detail, discussing them in relation to relevant literature, and to the findings of 58 in-depth interviews with prisoners and staff at an adult male prison.

To set the theoretical research context, Chapter 1 discusses issues around the definition of self-harming behaviours, and their prevalence in prisons across England and Wales. Following a brief review of the limited literature available on non-suicidal self-harm in custody, this chapter considers how (suicidal and non-suicidal) self-harm, and especially male self-harm, have been researched and constructed, both in prisons and outside.

Chapter 2 delineates the 'praxis' guiding this research, including questions of method, methodology, reflexivity and ethics. In a loosely chronological order, it traces the main steps through which this study has evolved and developed: starting from the original designing of the research, to the conduct and analysis of the interviews. The main tensions and dilemmas encountered at each stage of the research process are highlighted, together with the theoretical, political and pragmatic considerations that have contributed to both defining and resolving these challenges.

To emphasise how self-harm is constructed in - and by - the prison environment, and to counter the notion that "vulnerable prisoners" (Liebling, 1992, 1995) are an isolated 'problem' to be addressed, it was decided that staff's views and responses to repetitive self-harm should be discussed and presented first. Due to a paucity of research on the impact of self-harm on prison staff, this topic is located within a broader literature on professionals' responses to self-injury. Chapter 3 reviews current approaches, knowledge and discussions of workers' reactions to self-harm. Chapter 4 applies these theories and findings specifically to prisons. In particular, it consider some of the reasons why dealing with this aspect of work may evoke hostile reactions in prison staff, including a discussion of the likely impact of repetitive, non-suicidal self-harm on officers, healthcare and specialist staff, and of how different staff groups may cope (or not) with this demanding area of work.

Chapter 5 is the first of four interlinked data chapters. It summarises and discusses the findings of interviews with staff on their views and experiences of working with

repetitive, non-suicidal self-harm. It considers what dominant and 'subjugated' discourses exist around self-harm, and how these were a) drawn upon by different staff groups, and b) (re)producing and/or resisting different implications and subject positions for prisoners who repeatedly self-harm.

In Chapter 6, the views and opinions of staff are then discussed in relation to those of prisoners, with attention focusing on how prisoners constructed, resisted and negotiated their identity as (male) 'self-harmers'. This is followed by a discussion of a) how the men perceived different staff groups' responses to their self-harm, and b) how they felt these reactions affected them and their self-injury.

In contrast, Chapter 7 considers the functions and implications of staff's constructions of self-harm for staff themselves, within the context of their work. To this end, it summarises staff's reports of the impact of this area of work on their personal and professional lives, and of their main difficulties and concerns in dealing with self-harm. It then proceeds to consider how and why dominant - and arguably negative - constructions of self-harm may offer a way of coping with this issue.

Chapter 8 considers issues of staff training, support and supervision, as possible 'solutions' to counter negative practices and discourses. Staff's views and suggestions for support are reported, and discussed in relation to clinical and applied psychological literature. The feasibility and potential dangers of different solutions to the delivery of staff support are also considered.

In Chapter 9, the findings of these four data chapters are brought together in a general discussion. Conclusions and critical reflections are also delineated, together with recommendations for future research and policy.

Chapter 1. Introduction

At the heart of this thesis are the stories, views and experiences of 38 members of prison staff and 20 adult male prisoners who were interviewed in relation to self-harm. By summarising, discussing and deconstructing their accounts, this research hopes to increase awareness and understanding of their complex and under-investigated needs, whilst providing a space for less stigmatising readings of non-suicidal self-harm in custody.

To set the scene, this chapter begins with a brief discussion of definitional issues and an overview of the extent of self-harm in prisons across England and Wales. It then briefly reviews the wider literature on suicide and self-harm in custody, within which non-suicidal self-injury has traditionally been addressed. This is followed by a more in-depth discussion of how (suicidal and non-suicidal) self-harm, and especially male self-harm, have been researched, both in prisons and outside. After a summary of the strengths, shortcomings and implications of preceding research, the main aims of this study are considered.

1.1 Definitional Issues

The term 'self-harm' is not precisely defined in this thesis, to avoid predetermining the scope of study. Nevertheless, critical of the tendency in the prison-based literature and policy to treat all self-harm as a prelude to suicide (notable exceptions are Rickford & Edgar, 2005; Snow, 2002a), in this research I draw a distinction between 'self-harm' (or 'self-injury') and 'attempted suicide'. Whilst not wishing to suggest that these are necessarily independent nor mutually exclusive (for a discussion see Hawton & Catalâan, 1987; Liebling, 1992; Williams, 1997), there is evidence that self-harm and (attempted) suicide are "two functionally different behaviours" (Favazza, 1998; HMCIP, 1999; Spandler & Warner, 2007). Therefore, failure to differentiate between them may miss important differences in meanings and intentions (Warren, 1997).

The suggested 'suicidal' versus 'non-suicidal' dichotomy is based on the intent presaging self-inflicted harm, as opposed to its circumstances, method or severity. Although the notion of intent is notoriously fraught with difficulties (Fairbairn, 1995;

HM Prison Service, 2001), it is arguably even more controversial to ignore one's intentions or motivations for self-harming – even if these are unclear. This is especially the case in prisons, where means to self-harm are more restricted. Potentially life-threatening methods and injuries cannot, of themselves, be taken as implications of suicidal intent.

To further emphasise the focus of this study, the term 'repetitive self-harm' is also employed. Still relatively infrequent in prisons, this term is not used here to describe the diagnostic criteria of the "repetitive self-harm syndrome" discussed in the clinical literature (Favazza & Rosenthal, 1990; Pattison & Kahan, 1983). Rather, "the word 'repetitive' distinguishes harming as a means of relieving strong emotions from parasuicide, or attempted suicide [...] the phenomenon of repetitive self-harm rules out a simple view that self-injury is inevitably a precursor to suicide" (Rickford & Edgar, 2005, p. 64). In other words, of interest here are not the potential differences between prisoners self-harming more or less frequently (see e.g. Ireland, 2000; Shea, 1993), but rather their doing so with no apparent suicidal intent. Nevertheless, this term is used in a more literal sense (i.e. to indicate *repetitive* acts of self-harm) in later chapters, when considering staff's responses to self-injury. Doing so seemed both useful and appropriate, following evidence that - regardless of suicidal intent - frequency or repetition of self-harm tend to influence how prison staff view the behaviour (Pannell, Howells, & Day, 2003).

The terms 'self-injury' and 'repetitive self-injury' are also used, with the same meanings. Although 'self-harm' is generally considered to be broader and more inclusive than 'self-injury' (Crighton & Towl, 2002; Howard League, 2003), both are common in prisons (Safer Custody Group, 2002), and are here used interchangeably.

1.2 The Extent of the Problem: Rates of suicidal and non-suicidal self-harm in custody

Although "accurately estimating comparative rates is fraught with difficulties" (Towl & Hudson, 1997, p. 60), rates of (suicidal and non-suicidal) self-harm in custody have been repeatedly shown to surpass those recorded in the general population, both in the UK (Crighton & Towl, 2002; HMCIP, 1990) and abroad (Camilleri, McArthur, & Webb,

1999; Lohner & Konrad, 2006). In England and Wales - which are the primary focus of this research - most studies have concluded that these are between four and twelve times higher than the already high (see e.g. Meltzer et al., 2002; NICE, 2004) rate in the general population (Meltzer, Jenkins, Singleton, Charlton, & Yar, 1999; Towl & Hudson, 1997).

Notwithstanding the many incidents of self-harm that may never go reported or recorded, recent figures suggest that rates of self-harm in prisons may be as high as 840 per 1,000 prisoners (across different prisoner populations - see e.g. Howard League, 2003), and that approximately 30% of all prisoners have engaged in some form of self-harm during the course of their incarceration (Brooker, Repper, Beverley, Ferriter, & Brewer, 2002; see also Meltzer et al., 1999). In 2006, there were approximately 23,355 recorded incidents of self-harm in custody, involving an estimated 6,000 prisoners (equivalent to 7.5% of the average prison population) (Safer Custody Group, 2007).

These findings are considered to be a cause for great concern, particularly given that people who harm themselves are at greater risk of committing suicide than those who do not (e.g. Safer Custody Group, 2002). Research has shown that up to 10% of those who self-harm die by suicide (Stanley, Gameroff, Michalsen and Mann, 2001). Moreover, in prison, approximately 50% of those who commit suicide have a history of self-injury (e.g. Dooley, 1990; Topp, 1979; Safer Custody Group, 2007). Also, and despite this being less widely acknowledged, prisoners' self-harm can place a considerable emotional, financial and practical burden on prison staff and authorities (Lohner & Konrad, 2006).

Along with others, the Safer Custody Group[1] (2001) has argued that reducing rates of suicide and self-harm amongst prisoners is "fundamental to our duty of care and hallmark of a civilised society" (p. 1). Indeed, this is a repeatedly stated Prison Service (see e.g. HM Prison Service, 2003) and public health priority (see e.g. Department of Health, 2002). To this end, a new, multi-disciplinary system was recently introduced under the name ACCT ("Assessment, Care in Custody and Teamwork"), aiming to

[1] The Safer Custody Group is the National Offender Management (NOMS) department responsible for making "prisons safer places in which to live and work" (Safer Custody Group, 2001, p. 1).

improve the "care of at risk prisoners" (see HM Prison Service, 2005a). Regrettably, despite this and several other initiatives to reduce the incidence of self-harm (see HM Prison Service, 2005a; HM Prison Service & Department of Health, 2006), recent evidence suggests that rates of self-injury are continuing to rise (Howard League, 2005; Paton & Jenkins, 2005; Safer Custody Group, 2007). This research aims to contribute to the growing body of literature intended both to further our theoretical understanding of this issue and to inform relevant policy.

As argued by Kilty (2006, pp. 163-164), "self-injury has been studied by scholars in a variety of disciplines and has subsequently been understood and thus constructed in a variety of ways". The following section reviews how self-harm has been researched and (mis)constructed within the prison-based literature (for a critique of research on suicide in prisons see Camilleri et al., 1999; Crighton, 2002), tracing some parallels with current and historical policy developments (for more in-depth analyses of prison policy in relation to non-suicidal self-harm see Kilty, 2006; Rickford & Edgar, 2005). Given the difficulties in making comparisons across different criminal justice systems (Crighton, 2002), the focus of this chapter is primarily on England and Wales. Nevertheless, and where appropriate, some international references are included.

1.3 The Social Construction of Prisoner Self-Harm: A review of the prison literature

Despite official policy and rhetoric having long emphasised the minimisation of suicide *and* self-harm in custody, for years the latter has been dealt with as a medical problem, generally addressed, or "buried" (Howard League, 1999), within the broader framework of suicide prevention. Most of the studies in this field have focused on attempted and completed suicides (e.g. Dooley, 1990; Shaw & Turnbull, 2006; Topp, 1979), or failed to distinguish between suicide and different forms of self-harm (e.g. Cullen, 1985; Liebling, 1992; Liebling & Krarup, 1993; Safer Custody Group, 2005). When self-injury has been considered, "the emphasis has been upon understanding and monitoring self-harm as a means towards the identification of suicide risks" (Camilleri et al., 1999, p. 14). In other words, self-harm has been predominantly researched - and 'managed' - as a proxy for suicide, rather than as an issue in its own right.

This approach to the study of self-harm rules out a priori that self-injury may not be a precursor to suicide, obscuring and potentially trivialising alternative meanings and motivations. Indeed, the priority given to suicides in custody may explain why non-suicidal self-harm was - and remains - frequently dismissed in prison circles as "manipulative, attention seeking, and, as such, unworthy of attention and/or effective treatment" (Snow, 1997, p. 50). As argued by the Howard League (2003), this was reflected in practice in that "there was no unified system for gathering data on the number of incidents in prisons [until 2000], care suites were under used, self-injuring behaviour was being routinely punished by prison staff and there was little analysis within the system about the distinction between suicide and self-injury" (p. 6).

Although this issue is still relatively eclipsed by the priority given to suicide prevention, some progress seems to have been made. Over the past few years, there have been a number of academic publications and government reports dealing with self-harm, separately from suicide (e.g. HM Prison Service, 2001; Howard League, 1999; Livingstone, 1997; Rickford & Edgar, 2005; Snow, 1997). Moreover, data collected via a new system[2] to record incidents of self-injury in prisons have suggested "numbers [...] and rates that are higher than both previous prison-based and community studies [had estimated]" (Safer Custody Group, 2003, p. 5). In turn, these findings have alerted researchers and policy makers to the importance of "emphasising the management of self-harm (within Prison Service and Establishment Strategies) in addition to suicide prevention, for all establishments" (Safer Custody Group 2003, p. 12). This is evident in the introduction of a number of formal and informal interventions to support prisoners who self-harm (see Howard League, 2003), and the development of a new training module for staff specifically on self-injury, as opposed to suicide prevention (see Safer Custody Group, 2004).

Nevertheless, this renewed interest in self-harm has not been extended to *all* types of self-injury. Both in research and practice, broad definitions of self-harm have tended to prevail, thus failing to distinguish between different forms and levels of self-injury. In the words of Crighton and Towl (2002, p. 51), this has meant "blurring the distinctions

[2] The F213SH (Self-Harm/Attempted Suicide Form) was introduced in December 2002 to "more accurately" record every incident of self-harm known to occur in custody (see Safer Custody Group, 2002).

between behaviours that may have clearly distinct motivations and functions for individuals" (see also Howard League 2003; Towl, 2000). Within this blurred picture of self-harm, and even when more precise definitions have been employed, suicidal outcomes and motivations have, once again, been given priority. Most studies on self-injury have mainly or only concentrated on suicidal and "near lethal" self-harm (e.g. Liebling, 1992; Liebling & Krarup, 1993; Medlicott, Paton, Wright, Pinder, & Borrill, 2004), often - rather worryingly - referred to as "serious self-harm" (see e.g. Arnold, 2005; HM Prison Service, 2003, 2004c; HMCIP, 1999; Liebling, 1992).

1.3.1 Non-Suicidal Self-Harm and 'Self-Harmers': The forgotten many

The data officially recorded by the Prison Service - and much of the relevant policy and literature - refer to "any act where a prisoner deliberately harms themselves, irrespective of the method, intent or severity of any injury" (HM Prison Service, 2003, para. 3.1.1). As a result, there is no information available regarding the incidence of non-suicidal self-injury in custody. Nevertheless, given that the overwhelming majority of self-harm incidents do not result in death, and that many are carried out by prisoners who self-harm repeatedly, it seems plausible to argue that most incidents of self-harm in custody are not motivated by suicidal intent (see also Safer Custody Group, 2007).

Of the estimated 6,000 prisoners who harmed themselves in 2006, 41% were reported to have done so more than once, and 14% to have self-injured five or more times. Although the majority of self-harming prisoners (59%) were found to have self-injured once, almost 20% of the incidents recorded in that year were carried out by just 1% of those who had harmed themselves (Safer Custody Group, 2007).

In view of these findings, it is both concerning and surprising that the Prison Service has only recently recognised that "tackling repetitive self-harm could be a useful strand of future work" (Safer Custody Group, 2007, p. 9; see also HM Prison Service, 2001). At present, there are no specific policies or procedures to address the needs of prisoners who repeatedly self-harm with no suicidal intent, and a very limited evidence base to suggest what these needs may actually be. This form of self-harm is not only often neglected and overlooked, but continues to be branded as *not* being 'serious', both in the literature and official policy (see e.g. Camilleri et al., 1999). This may stigmatise

prisoners, reinforcing the notion that their self-harm is merely "attention-seeking and manipulative" (Snow, 1997, p. 58), and reproducing the feelings of isolation, low self-worth, and loss of control that may have led to their self-harming in the first place (Johnstone, 1997). Moreover, this inattention to repetitive, non-suicidal self-harm may belittle the stress and anxieties involved in working with this complex behaviour, with the effect of devaluing staff and (where applicable) leaving their professionalism unappreciated.

1.3.2 Male Non-Suicidal Self-Harm and 'Self-Harmers': The "almost invisible"[3] many

The few studies dealing with repetitive, non-suicidal self-injury in custody have almost exclusively been conducted with women prisoners (e.g. Howard League, 2001; Loucks, 1997; Snow, 1997), and male and female young offenders (e.g. Liebling, 1992). As a result, there is currently little understanding of this issue amongst adult male prisoners (Fulwiler, Forbes, Santangelo, & Folstein, 1997; Thomas, Leaf, Kazmierczak, & Stone, 2006), nor of the specific factors which may increase their vulnerability to self-harm. Similarly, little is known about the experiences, reactions and needs of staff dealing with adult men who repeatedly self-injure. Arguably, it is important to increase knowledge and awareness of these issues, and the ways in which they may be addressed. Although seemingly less likely to self-harm than women prisoners or young offenders (cf. Maden, Chamberlain, & Gunn, 2000), adult males are disproportionately represented in the prison population and account for over half of all recorded incidents of self-harm in prisons in England and Wales (Howard League, 1999; Safer Custody Group, 2007). For instance, in 2006 there were 11,874 incidents of self-harm recorded amongst men in custody, involving nearly 5,000 prisoners (6% of the total male prison population) (Safer Custody Group, 2007). Of these, nearly 40% self-harmed more than once, and 10% did so more than five times (*Ibid.*). In addition, data pertaining to lifetime prevalence suggest that there are no significant gender differences in prisoner self-harm, and, therefore, that this should not (only) be considered "as a problem in (sic) female prisoners" (Maden et al., 2000, p. 203).

[3] Taylor (2003a, p. 83).

Given the lack of research specifically on male, non-suicidal self-harm it is useful to locate this topic within the wider literature on (male and female) self-harm. As many of the studies in this field have used broader and less clearly defined terms, it is not always clear whether their findings may refer to suicidal and/or non-suicidal forms of self-injury. Nevertheless, research dealing exclusively with attempted or completed suicides has not been included in the following review, to avoid further eclipsing the issue of self-harm and its non-suicidal meanings.

1.3.3 Research on Self-Harm in Prisons

Both in the UK (Ireland, 2000; Maden et al., 2000; Shea, 1993) and abroad (Fotiadou, Livaditis, Manou, Kaniotou, & Xenitidis, 2006; Fulwiler et al., 1997; Ivanoff, 1992; Lohner & Konrad, 2006), most studies focusing on self-harm in prisons have been concerned with prevalence, risk factors and clinical concomitants. In turn, this body of research may be located within - and across - two main conceptual paradigms. On the one hand, psychiatric and psychological studies focusing on the "imported vulnerability" of "at risk" prisoners (see e.g. Camilleri et al., 1999); on the other, sociological analyses of the role of imprisonment itself in precipitating self-harm. It is to these, respectively, that the discussion now turns.

1.3.4 The "Psy-Literature" on Prisoner Self-Harm: "Imported vulnerability" and risky individuals

Over the last two decades, several studies have been conducted in an effort to identify the common features of those prisoners most likely to self-injure, i.e. to establish a profile of the "vulnerable" (Liebling, 1992), high risk prisoner, which could assist the prediction and prevention of (suicidal) self-harm in custody (for a review see Crighton & Towl, 2002; Livingstone, 1997). Consistent with studies of self-injury outside prison, these have suggested that the risk of self-harming is statistically associated with being 'White'[4] and relatively young (particularly in relation to non-suicidal self-harm), coming from disadvantaged social, economic and familial backgrounds, and having experienced or witnessed some form of emotional, physical and/or sexual abuse. Rates of self-injury have also been found to be especially high amongst prisoners with a history of

[4] As this category is seldom broken down, there is currently insufficient evidence to suggest which 'White' group or groups may be at increased risk of self-harming in custody.

psychiatric disorder and treatment, a past of alcohol and/or drug dependency, and previous self-injury. Further risk factors include poor coping and problem solving skills, close affiliation with someone with a history of self-harm, and high levels of aggression, impulsivity, anxiety and distress. Acts of "violence against others" and "violence to self" (HMCIP, 1999) have also been linked in the literature. Compared to "non-self-harmers" (Dear, Thomson, Howells, & Hall, 2001), self-harming prisoners are seemingly more likely to have been convicted for sexual and violent offences, to be serving longer sentences, and to have a history of disciplinary infractions.

Depending on their exact focus, these "psy-studies" (Rose, 1985) have contributed to creating a picture of self-harm as "a complex and difficult to manage clinical problem" (Chowanec, Josephson, Coleman, & Davis, 1991, p. 202), "a symptom of pervasive maladjustment" (*Ibid.*, p. 203) and/or "of long term personality problems" (Maden et al., 2000, p. 199), including "severe psychopathology" (*Ibid.*; see also Wilkins & Coid, 1991). As contended by Kilty (2006), in so doing they have implied that self-injury is irrational, meaningless and a threat to the security of the institution. This, in turn, can legitimise punitive and tautological responses to self-injury, with prisoners' needs being re-constructed as institutional risk factors to be controlled and (self)governed. In other words, and particularly, within the "risk culture" (Lupton, 1999) that permeates the Prison Service (see e.g. Carlen, 2002; Rickford & Edgar, 2005), this - and the tendency to view all self-harm as a precursor to suicide - can lead to constructing prisoners who self-harm as dangerous and risky, to others and to themselves. As a consequence, their needs become overridden by security concerns and by the imperative of preventing deaths in custody. As noted by Thomas et al. (2006, p. 196), "the problem may be even more extreme in male prisons, in part because of the higher level of aggression among male inmates, and because their SIB [self-injurious behaviour] tends to be more violent".

Whilst (over)emphasising the psychiatric illnesses and/or psychological deficiencies of those who self-injure, these studies have tended to overlook the environmental, organisational and relational correlates of self-harm in custody. On these grounds, they have been accused of failing either to explain or predict prisoner self-harm (see e.g. Liebling, 1992). Indeed, by pathologising and decontextualising this issue, these studies

may seem to suggest that prisons can do little or nothing to prevent its occurrence. From this perspective, high rates of suicide and self-harm in custody are due to the prison population being – or being *selected* to be (Liebling, 1995) – disproportionately at risk of self-injury.

1.3.5 The Sociological Literature on Prisoner Self-Harm: From risky individuals to risky situations

Dissatisfaction with this individualistic model led sociological researchers to focus on the situational factors that may increase the risk of self-harm in custody. Whilst the emphasis on risk has remained pervasive (and arguably problematic), attention has shifted away from risky individuals and backgrounds, to risky times, cultures and regimes (for a more detailed review see Crighton & Towl, 2002; Livingstone, 1997).

Nights, early mornings and weekends were all found to be times of 'high risk', as were withdrawing from drugs and alcohol, being transferred to another prison or hospital, receiving bad news and experiencing relationship problems (either inside or outside prison). Prisoners on remand, 'lifers' and 'first timers' (see glossary) were also reported to be more vulnerable, especially in early periods of custody and in local prisons. Further factors include the lack (or avoidance) of "purposeful activity" (see glossary), being physically and socially isolated (e.g. in segregation, or in a single cell), and being bullied by other prisoners or staff. Indeed, the overall social and "moral climate" (Liebling & Arnold, 2004) of a prison has been described as a crucial risk factor in self-harm (and suicide), particularly in relation to prisoners' perceptions of relationships, safety, care and fairness (Liebling, Tait, et al., 2005). In turn, all of these are thought to be affected by overcrowded conditions and associated problems of low staff levels, training and morale (Rickford & Edgar, 2005).

Overall, these findings have contributed to re-framing self-harm (and suicide) as an outcome of prison-induced distress, rather than a symptom of individual illness. Both in policy and research, this has led to a fundamental re-examination of existing practices (McHugh & Snow, 2002), with greater attention being paid to the psycho-social dimensions to self-harm amongst prisoners, and to the need to explore and address this issue in a holistic way (see e.g. HMCIP, 1999).

1.3.6 From Prediction to Verstehen: Exploring and explaining prisoner self-harm

A parallel and positive development in the literature has been the shift towards trying to understand and prevent prisoner self-harm. The old "predictive approach" (Liebling, 1992) had contributed to identifying a large number of individual and situational factors associated with the prevalence of self-injury. However, none of these are actually diagnostic, many of them co-occur, and, on the whole, they describe a large percentage of those in custody. Therefore, despite being seemingly valid and reliable, these findings have tended to over-identify those who do not go on to self-harm and under-identify those who do. Moreover, and in the words of Liebling (1992, p. 105), "the individual prediction approach [...] has inherent limitations in the study of human social action".

Alison Liebling (1992) has been an influential and vociferous proponent of the view that "explanatory understanding" (or "verstehen"; see also Hollway, 1989), rather than prediction, should be the central aim of research on suicide and self-harm in custody (see also Inch, Rowlands, & Soliman, 1995). Although her extensive research on this topic has tended to focus on suicidal forms of self-harm, Liebling has also provided an important model for the study of non-suicidal self-injury. Arguably, the emphasis on verstehen offers a more appropriate and achievable focus for this research (as well as that on suicide), and is ultimately more useful in relation to policy than an (over)predictive approach.

Some studies have embraced this "new direction in research" (Liebling, 1992) by adopting a more dynamic and interactionist conceptualisation of risk. Rather than exclusively relying on static, statistically derived factors, this body of research is concerned with how these factors interact, how they may be mediated or moderated at an individual and institutional level, and what significance they may hold in the aetiology of self-harm. For instance, styles of coping (Brown & Ireland, 2006; Power, McElroy, & Swanson, 1997) and self-expression (Marzano, 2001) have been explored, as potential interactional factors (Zamble and Porporrino, 1988) that may place some prisoners at particular risk, in high-risk situations.

Nevertheless, and despite their greater explanatory power, these studies remain located within a positivistic, (quasi)experimental paradigm. In the quest to produce quantifiable

and generalisable data, they have tended to use quantitative methods, privileging parsimony over complexity, so-called objectivity over subjectivity. In so doing, they have arguably failed to capture the complexity and the multidimensional nature of self-harm (McAllister, 2003a).

1.3.7 (Pseudo)Qualitative Research on Prisoner Self-Harm: Exploring and classifying prisoners' motivations

A different, and arguably more valid, approach to the study of self-harm amongst prisoners is "to include direct interviews with the prisoners concerned" (Inch, Rowlands, & Soliman, 1995, p.164), with the aim of eliciting their motivations. From a phenomenological perspective (Husserl, 1931), understanding self-harm involves exploring the views and experiences of those who self-injure. In the words of Blaikie (1993, p. 176), "it is the meanings and the interpretations, the motives and the intentions, which people use in their everyday life and which guide their behaviour". As argued by Kilty (2006), a participant-centred perspective is not only useful in terms of achieving verstehen, but is also necessary "if [self-harm] policy is to be effective" (p. 174; see also Thomas et al., 2006).

However, and whilst employing qualitative methods, most of the (few) interview studies on this topic have failed to distance themselves from the positivist paradigm of the risk literature, often treating these subjective accounts as risk factors in themselves. The views and experiences of self-harming prisoners have frequently been quantified and/or compared to those of "normal" prisoners (e.g. Dear et al., 2001; Liebling, 1992; Liebling & Krarup, 1993), arguably – once again – at the expense of achieving verstehen. For instance, in one of the rare studies to consider adult male prisoners *and* non-suicidal self-harm, Snow (2002a) classified and content analysed individuals' (self-reported) reasons for self-harming in a way that may indeed allow for statistical analyses, but loses the richness and complexity of qualitative data. The recurrent quest for a predominant motivation for self-injuring (e.g. Jeglic, Vanderhoff, & Donovick, 2005; Klonsky, 2007; Snow, 2002a) also over-simplifies a phenomenon that may indeed not have *a* static or predominant motivation (see e.g. Rayner & Warner, 2003; Turp, 2002). The following section discusses the findings and implications of these studies, particularly in relation to male self-harm.

1.3.8 The Social Construction of Male Prisoner Self-Harm: Gendered assumptions of a gender-blind literature

To date, there has been very little research on the presumed motivations of adult male prisoners who self-harm with no suicidal intent. When these have been considered, the tendency has been to quantify and hierarchically classify them. Moreover, most of the studies in question seem to have failed to explore fully the richness of narratives produced by interviewees, or the possible assumptions within their analyses. Despite occasionally acknowledging the potential roles of gender (and of different ways of performing gender) in self-harm and self-reports of self-harm, these investigations have often reflected and perpetuated a variety of gendered assumptions.

Like most of the (scarce) non-prison literature on this topic (e.g. Hawton, 2000), the emphasis has tended to be on gender differences, rather than similarities, with men being portrayed as more active, violent, and "instrumental" than women, as well as less likely to be distressed and "emotional" (see e.g. Snow, 2002a; Thomas et al., 2006). For example, the World Health Organisation (WHO) (2000) has concluded that "incarcerated men with antisocial or sociopathic personalities may be more prone to manipulative attempts [...whereas] for incarcerated women, repeated self-mutilation (such as slashing or burning) may be a response to the stress brought on by confinement and the prison culture" (p. 11). The very same behaviour (i.e. "repeated self-mutilation") is constructed as a 'genuine' way of coping with stress, where women are concerned, but assumes the more negative connotation of a "manipulative attempt", where men are involved.

However, there is very little evidence to support these claims. In addition, there has been little discussion or agreement as to what actually counts as a "manipulative" or "instrumental" motive. For instance, in a study of "parasuicidal" behaviour amongst Scottish male young offenders, Power and Spencer (1987) interpreted self-harming to avoid harassment from other prisoners as an "instrumental motivation". Under this same category, Snow (2002a) included reasons as varied as wanting "changes in medication" and "transfer", "being alone" and "wanting someone to talk to". Rivlin (2006), on the other hand, discussed taking "revenge for a perceived injustice perpetrated by the prison

staff" and "wanting attention and sympathy" as examples of "goal-oriented", "practical" self-harm.

It is questionable whether classifying these motives within broader categories is actually useful and, if so, whether the label "instrumental" (as opposed to interpersonal or situational) provides an adequate description for any of these alleged motives. Arguably, the quantitative emphasis of these interview studies has meant that the possible reasons and functions of these presumed motivations have often remained overlooked, as have the negative repercussion of attributing instrumental, practical and manipulative motives to self-injury.

Furthermore, it is perhaps inappropriate to compare or make assumptions about the motivations of different groups of prisoners, given that most interview studies on non-suicidal and repetitive self-harm (as opposed to suicide or attempted suicide) have been conducted with women (Howard League, 2001; Loucks, 1997) and young offenders (Cullen, 1985; Inch et al., 1995; Power & Spencer, 1987). This, in itself, serves to reinforce the "myth" of self-injury as a gendered and developmental phenomenon (Shaw, 2002, p. 192). Arguably, it is because of this very stereotype that more research should be conducted with men who self-harm *and* "naming men [who self-harm] as men" (Hanmer, 1990). Particularly in the hyper-masculine context of prisons (Newton, 1994; Ryder, 1994), the conceptualisation of self-injury as essentially a female and/or teenage activity (see e.g. Brickman, 2004), and dominant assumptions about how men should be, feel and act, are likely to influence how self-harm is constructed and understood by perpetrators themselves, staff, policy markers and researchers.

1.3.9 Sociological Qualitative Analyses of Prisoners' Motivations for Self-Harming

Although more in-depth - and less stigmatising - accounts of male prisoners' motivations for self-harming have been reported, these have once again focused on prisoners thought to self-harm with suicidal intent (Liebling & Krarup, 1993; Medlicott et al., 2004), on the grounds that exploring their "subjective experiences" may "provide important information about motivations for completed suicide" (Inch et al., 1995, p. 162). In addition, most of these studies have been conducted from a sociological perspective. Whilst bringing attention to the damaging effects of imprisonment

(Rickford & Edgar, 2005) and thus to the importance of exploring prisoners' experiences of being in custody (see e.g. Liebling, 1992), these studies have often disregarded the vast psychological literature on self-harm *outside* prison.

Whilst much of the "psy-literature" (Kilty, 2006) on self-harm in prisons has focused on risk factors, there is a wider psychological literature exploring the meanings, functions and origins of self-injury. Unlike most prison research, much of this literature considers self-harm in isolation from suicide, often distinguishing between non-suicidal self-harm and attempted suicide. Although these studies have been conducted outside the context of prisons and almost exclusively with women, they are also pertinent to men in custody. Furthermore, many of those who self-harm in prisons began to do so outside of prison (Karp, Whitman, & Convit, 1991; Livingstone, 1997), and often continue to self-harm following release from custody (Howard League, 2002). Therefore, it is also useful to explore prisoner self-harm in relation to events and experiences that are not strictly related to imprisonment. It is to these that the discussion now turns.

1.4 Psychological Research on Non-Suicidal Self-Harm Outside Prison

Particularly since the mid 1980's, there has been a surge of psychological studies aimed at understanding, exploring and/or explaining self-harm (for an historical overview see Shaw, 2002), from psychodynamic (Gardner, 2001; Menninger, 1935; Miller, 1994), bio-social (Linehan, 1993; Van der Kolk, Perry, & Herman, 1991), cognitive-behavioural (Chapman, Gratz, & Brown, 2006; Walsh & Rosen, 1998) and systemic perspectives (Babiker & Arnold, 1997; Chantler, Burman, Batsleer, & Bashir, 2001; Spandler & Warner, 2007). Although there is still a lack of understanding and evidence as to what causes (non-suicidal) self-harm and how it could be prevented, a recurrent theme in this literature is that issues of trauma, abuse, powerlessness and neglect (and associated neurobiological, cognitive and/or psychodynamic mechanisms) play an important role in initiating and maintaining this behaviour. Furthermore, research has consistently shown that self-harming can serve a variety of functions and meanings for those who self-injure (see e.g. Arnold, 1995; Klonsky, 2007), and may provide a sense of relief and control over feelings of anxiety, depersonalisation, anger and helplessness, as well as over one's environment. Further functions are thought to include regulating and expressing distress, attracting sympathy and comfort, influencing and punishing

others, as well as providing a distraction from emotional pain. Self-harming has also been conceptualised as a form of self-punishment and/or self-soothing, a means of re-enacting trauma, self-cleansing, and, perhaps more controversially, achieving sexual gratification (see e.g. Connors, 1996; Gardner, 2001; McAllister, 2003a).

By bringing attention to individuals' (apparent) reasons for self-injuring with no suicidal intent, these studies have challenged the notion that self-harm is inevitably linked with or lead to suicide. Indeed, this behaviour has sometimes been argued to be the very opposite of suicide, and reframed as a survival and coping strategy - albeit perhaps a maladaptive one (Fillmore & Dell, 2000; Spandler & Warner, 2007). Moreover, and despite their different emphases and assumptions, these studies have helped to move away from the medical conceptualisation of self-harm as a physical and/or mental illness (e.g. Pattison & Kahan, 1983; Tantam & Whittaker, 1992), which was especially dominant until the 1990s and, in many ways, still is (see Cresswell, 2005; Johnstone, 1997). Whilst often also tending to individualise the "distorted thoughts" (Walsh & Rosen, 1998) and "impulses" (Williams & Pollock, 2000) thought to underlie self-harm (see Kilty (2006) for a critique of the "psy-literature"), they have suggested that this behaviour is more usefully conceptualised as a sign of psychological distress. At times - but not always - this has contributed to shifting attention and stigma away from individuals' psychological (dis)functioning, to the feelings, events and experiences that may underlie them.

1.4.1 Feminist Contributions: Understanding self-harm in a systemic and relational way

Feminist psychological accounts have arguably made an especially valid contribution to our understanding of self-harm, by emphasising that individual actions need to be understood within the context of people's lives and experiences (rather than their psychological deficiencies), *and* in relation to broader systemic issues. As contended by Arnold and Babiker (1997, p. 37), "the 'language' of injury may be a means by which individuals 'speak' about what are social and political, as well as personal experiences", including physical, emotional and sexual abuse, domestic violence, poverty, racism and homelessness (see e.g. Chantler et al., 2001; Harris, 2000; Spandler & Warner, 2007; Strong, 1998). Seen in this way, self-harming is not only "a necessary though unhealthy way of responding to [and coping with] distressing and oppressive conditions" (Fillmore

& Dell, 2000, p. 9), but also an act of defiance and resistance, a way of regaining some power (see e.g. Brickman, 2004).

Although much feminist psychological work in relation to self-harm has been conducted with women (see Ch 3.1.5), this systemic and relational reframing of self-harm may also lend itself to an analysis of male self-injury – particularly, perhaps, within the disempowering, alienating and fear-inducing context of imprisonment (Adler, 1997; Sykes, 1958; Toch, 1992b). Babiker and Arnold (1997, p. 44), for instance, have contended that the relatively high rate of self-injury amongst male prisoners is mainly due to men in prison "being subject to experiences which are normally more likely to be suffered by women" (see also Warner & Wilkins, 2004). As concluded by McAllister (2003a, p. 181), "new feminist discourses suggest that it [the issue of self-harm] is more to do with power and resistance than it is to do with gender".

However, what has yet to be explored in any depth is whether and how being male – and performing different versions of masculinities – may influence the meaning(s) of these experiences and of one's self-harm (notable exceptions are Elliott, n.d.; Taylor, 2003a). For instance, in an "exploratory study" of six men's experiences of their self-injury, Elliot (n.d., p. 2) found "some overlap with women-centred literature", but "a fundamental difference was the influence of dominant discourses about masculinities which excluded many of the participants". This, and the pressures of "being a bloke", were said to contribute to further distress and self-harm. As commented by Taylor (2003a, p. 87):

> The Western conceptualisation of self-harm as essentially female behaviour could lead men to be ashamed because their self-harm appears to make a lie of their attempts to 'constantly reassure themselves that they are men, not women' (Horrocks, 1994, p. 90).

Arguably, these pressures are likely to be even stronger in the "ultra-macho" (Cowburn, 1998; Newton, 1994) context of imprisonment, where, however, they have rarely been acknowledged. Also worth considering is whether the discourses suggested by some feminists as positive re-conceptualisations of self-harm may actually 'work' in relation to men, particularly 'criminal' men. For example the idea of self-harm as an attempt to

gain power and demonstrate agency may be viewed more positively when applied to the "White, suburban, attractive teenage girl [who] persists as the face of self-mutilation" (Brickman, 2004, p. 87), than it would when considered in relation to male prisoners. Indeed, even in relation to women prisoners, "it seems to be beyond the scope of correctionalism to view resistance as anything but a threat to the security of the institution" (Kilty, 2006, p. 165).

1.4.2 From Causes and Motivations to Constructions and Responses: Deconstructing self-harm

Some feminist accounts have not only helped to explain what may cause self-harm (and prisoner self-harm), but also why and how certain forms of self-harm are problematised and pathologised and others are not - or not to the same extent. Shifting away from the conventional concern with aetiology, and the modernist quest for a "grand theory" (McAllister, 2001) of self-harm, post-structural feminists have discussed this as a cultural, social and political phenomenon, produced and reinforced by shifting, contested and situated forms of knowledge and language, and associated relations of power (see e.g. Cresswell, 2005; McAllister, 2001; Shaw, 2002).

As argued by Connors (1996, p. 198), "behaviour alone does not constitute self-injury"; rather it is the way(s) in which different behaviours are constructed that define them as self-injurious. Indeed there are many examples of behaviours which, despite being 'harmful', are (or have been) socially sanctioned or even encouraged. These include cosmetic surgery, drinking, smoking, over-working, and a wide variety of religious and medical practices (Favazza, 1996). This suggests that rather than - or, as well as - focusing on the possible functions and causes of self-harm, it is important to explore and deconstruct how (different types of) self-harm and prisoner self-harm become problems to be addressed. In turn, this involves focusing on how these are constructed and explained by perpetrators themselves, and, perhaps even more importantly, by the people, disciplines and systems with the power to define and label their behaviour as 'self-harm'.

The latter approach may actually offer a more useful focus for one's analysis than to (only) consider the perspectives of those who self-injure. Exploring the cultural and

professional reactions to self-harm may help to both de-individualise and contextualise this issue. Furthermore, there is evidence that the stigma and shame attached to some forms of self-harm, and the ways in which 'carers' and professionals respond to "self-harmers" (Dear et al., 2001), can significantly exacerbate their distress, leading to further and more severe self-harm (e.g. Clarke & Whittaker, 1998; Pembroke, 1991). Thus, exploring these responses may not only reveal *how* self-harm is 'created', but also *why* it may persist and potentially escalate.

1.5 Integrating Psychological and Sociological Perspectives

Psychological, and especially feminist psychological accounts of self-harm outside prison are not antithetical to sociological analyses of prisoner self-harm, and may indeed contribute to explain why so many prisoners self-injure, and why their behaviour tends to be conceptualised in certain ways. Whilst sociological analyses may help to understand prisoner self-harm at the meso-level of the institution, integrating these with the broader psychological literature may help to conceptualise this issue at a micro ***and*** macro level. Arguably, this entails contextualising self-harm within the individual experiences of those who self-injure (i.e. in relation to their lives both inside and outside prison), and exploring how their behaviour is constructed within the prison environment, as well as a within wider societal discourses that shape and constrain the latter.

Arguably, *non*-prison-related factors and theories cannot be excluded from an analysis of self-harm in custody. Nevertheless, there are theoretical, practical and political advantages in privileging prison-related factors and experiences. Current (and thus prison-related) symptoms, events and situations are seemingly the most commonly cited precipitants of self-harm amongst prisoners (Dear et al., 2001; Inch et al., 1995), and are possibly easier to modify, manage and prevent. This is perhaps especially true of staff's attitudes and responses to self-injury, which, in recent years, have been shown to be both a potential trigger (or risk factor) for self-harm, and a crucial protective and preventative influence.

Following Liebling and Krarup (1993, p. 172), there is now considerable agreement that "staff hold the key to their [prisoners'] safe and humane custody, and to the minimisation of suicide [and self-harm] risk in this context". Prison staff can possibly

make the single most important contribution to this area by identifying prisoners at risk, supporting and talking to them at difficult times and, in so doing, making them feel safer, cared for and trusting (Liebling, Tait, et al., 2005; Rickford and Edgar, 2005).

1.6 Review of the Prison-Based Literature on Staff's Responses to Self-Harm

Despite increasing recognition of the crucial role of staff in the prevention and management of suicide and self-harm in prisons (e.g. Rowan, 1994; Towl, 2000), there has been very little prison-based research on the attitudes, experiences and needs of staff dealing with this issue. This is particularly the case when considering staff working with prisoners who repeatedly self-harm with no suicidal intent. Most of the (few) studies exploring the impact of self-harm on staff either fail to distinguish between different forms of self-harm and suicide (e.g. Cullen, 1985; Liebling, 1992; Liebling & Krarup, 1993; Safer Custody Group, 2005), or only consider staff working with prisoners who attempt (e.g. Towl & Forbes, 2002) or complete suicide (e.g. Borrill, Teers, Paton, Regan, & Cassidy, 2004; Crawley, 2004; Snow & McHugh, 2002; Wright, Borrill, Teers, & Cassidy, 2006). This is in spite of evidence that staff tend to distinguish between different types and levels of self-harm, and to respond especially negatively to prisoners whose self-harm is a) repetitive and b) not seemingly motivated by suicidal intent (Pannell et al., 2003; Snow, 1997). This may exacerbate their distress and increase the already high likelihood of their committing suicide (Towl and Forbes, 2002).

> The general attitude to self-harm and suicide prevention [amongst prison staff] appears to be one that assumes self-harm is a precursor to suicide and that it is manipulative behaviour, to gain improved conditions or attention. Most staff regard attention-seeking behaviour negatively. (McDonald & Sexton, 2002; as quoted in Rickford & Edgar, 2005, p. 65)

Once again, the few studies dealing with staff's reactions to repetitive, non-suicidal self-injury have almost exclusively been conducted in female establishments (e.g. Howard League, 2001; Loucks, 1997; Snow 1997) and (male) young offender institutions (e.g. Liebling, 1992). In view of the popular construction of self-harm as essentially a female and/or teenage activity, it is possible to speculate that adult male self-injury may leave

staff feeling more perplexed and unprepared, and may be interpreted as being less 'genuine'.

The different cultures and regimes, as well as the quality and level of training and support available in different types of establishments, may also affect staff's responses to repetitive self-injury. For instance, research carried out by the Safer Custody Group (2005) found that in local adult male prisons "the effect on staff of suicide and self-harm was felt as a threat to staff themselves and their stability" (p. 2). In contrast, and despite the much higher rates of self-harm reported amongst women prisoners, there appeared to be no significant correlation between dealing with prisoner self-harm and staff well-being in female establishments. In other words, "the link between dealing with self-harm in prisoners and staff stress which was evident for local prison staff did not apply in female establishments" (*Ibid.*, p. 4). The authors tentatively suggest that this might be related to the development of "stress immunity", the event of female prisoner self-harm being "intrinsically less stressful" than male self-injury (*Ibid.*), and/or the better level of post-incident support reported in female establishments.

Whilst a comparison of the possible impact of self-harm on staff in different types of establishments is beyond the scope and remit of the current research, it is important to note that the findings from previous studies in this area may not necessarily be generalised across the whole prison estate, and that further work is needed to increase knowledge and awareness of the issues and concerns of prison staff dealing with adult male prisoners who repeatedly self-injure, with no apparent suicidal intent.

Furthermore, at a conceptual level, these studies have mainly sought to expose staff's negative attitudes or test their limited knowledge of self-harm, rather than trying to explain, understand and/or deconstruct them (see Ch. 3 and 4). Arguably, in an attempt to de-individualise and de-pathologise prisoner self-harm and suicide, research has ended up individualising and de-contextualising the responses of staff. As a result, wider systemic issues remain, once again, overlooked.

Moreover, this approach ignores that "self-injury is an enormously difficult behaviour to manage and to work with" (WHO, 2000, p. 11; see also HMCIP, 1999). As staff are the ones who most often discover and deal with self-injury in prisons, their welfare must be also considered. Exploring the impact of self-harm on staff, understanding their needs and offering suitable training, support, and supervision may reduce staff stress and burnout (Bowers, 2002; Burrow, 1992), contribute to creating a supportive environment for those at risk of suicide and self-harm (Liebling & Chipcase, 2001), and generally enhance the regime (Adler, 1999; Liebling et al., 1999). Helping staff to cope with this potentially stressful area of work may also have benefits for the National Offender Management Service (NOMS) in terms of reducing staff sickness and turn-over rates (Bailey et al., 2000).

In addition, most of the literature concerned with staff in prisons, including research on their responses to prisoner self-harm, has predominantly and often exclusively focused on uniformed discipline staff, particularly prison officers (e.g. Arnold, 2005; Borrill et al., 2004; Crawley, 2004; Liebling & Krarup, 1993). Indeed, the term "prison staff" has often been used as a synonymous for "prison *officer*" (e.g. Liebling, Tait, et al., 2005; Willmott, 1997), even when reporting the findings of research conducted with staff from other disciplines. However, in the context of the recent shift in policy and practice towards multi-disciplinary team work (see HM Prison Service, 2005a; McHugh & Snow, 2002; Rickford & Edgar, 2005), a variety of staff are involved in the care and management of self-harm in custody, including healthcare and mental health professionals, education staff, Samaritans, psychologists and chaplains. Although they may have less day-to-day interaction with prisoners who self-injure, they are also likely to affect and be affected by this issue, and thus need to be included in relevant studies.

1.7 Summary of the Previous Literature on Prisoner Self-Harm

In recent years, the issue of self-harm in prisons has gained increasing prominence and attention. However, as is evident from the literature reviewed in this chapter, most empirical research on this topic has failed to explore the experiences and concerns of prisoners, especially men, who repeatedly self-harm with no apparent suicidal intent. When these have been considered, the ways in which they have been researched and

constructed have often been stigmatising and arguably unhelpful. The same might be said with regards to the views and experiences of staff working with this complex behaviour.

Although the existing literature has provided a crucial foundation upon which further research can be based, there are a number of acknowledged shortcomings:

1. The focus on suicide and suicide risk

In prisons, distinctions between suicide and self-harm have been traditionally "subordinated to the imperative of preventing deaths in custody" (Groves, 2004, p. 54). Even when they have not, the meanings and motivations of non-suicidal forms of self-injury have tended to be overlooked, trivialised, and "feminised" (Brickman, 2004).

2. The focus on women and young offenders

The few studies concerned with non-suicidal forms of self-harm have focused on women prisoners and male and female young offenders. This reinforces the "myth" of self-injury as a gendered and developmental phenomenon (Shaw, 2002, p. 192), and fails to explore how this very myth impacts on men who self-harm and staff working with male self-injury.

3. The lack of phenomenological analyses

Whilst descriptive and predictive analyses of prisoner self-harm have abounded, relatively few studies have tried to capture the subjective experiences of those who self-harm in custody, or of those who have to deal and work with this complex behaviour – particularly in relation to male, non-suicidal self-harm.

4. The sociological focus

Sociological analyses of prisoner self-harm have made an important contribution to this field by a) employing a more qualitative and holistic approach, and b) bringing

attention to the role of imprisonment itself in the production and persistence of this issue. However, these have often ignored the role of individual factors and the clinical, psychological and feminist literature on self-harm outside prison.

4. The lack of deconstructive analyses

Few studies have considered the ways in which self-harm is constructed and problematised in prisons (notable exceptions are Groves, 2004; Kilty, 2006; Thomas et al., 2006). Arguably, exploring and deconstructing the ways in which certain forms of self-harm come to be defined as a "problem to be managed" (Groves, 2004, p. 51), can increase our understanding of this phenomenon and open a space for alternative, less stigmatising discourses and practices.

5. The lack of literature on staff

Whilst certainly not the only factor in prisoners' self-harming behaviours or the ways in which these are conceptualised, staff are often thought to have the strongest and most influential impact on self-injury in prisons. In spite of this, they have often been neglected in the literature surrounding self-harm in prisons (notable exceptions are Liebling, 1992; Liebling, Tait, et al., 2005; Snow, 1997). When they have been consulted or 'tested' in relation to this topic, there has been a tendency to only consider the views of officers, and, once again, to focus on a) suicide and suicidal self-harm and b) *female* non-suicidal self-injury.

1.8 The Present Research

Given these shortcomings, the present research aims to explore and deconstruct the experiences, issues and needs of prisoners and (different types of) staff dealing with male repetitive non-suicidal self-harm. Focusing specifically on this form of self-harm is not intended to suggest that this is necessarily different from other types of self-injury, nor does it wish to reinforce the unhelpful dichotomising of 'serious' and 'non-serious' self-harming behaviours. Rather, the intent is to provide a space to explore a phenomenon often eclipsed by the priority given to suicide in custody. Similarly, by

exploring male self-harm, my aim is not to isolate this phenomenon from that of female self-injury, but to create greater awareness and understanding of an issue that "in men is even less acknowledged, accepted and understood than it is in women" (Taylor, 2003a, p. 83). Creating more awareness of male self-harm may also help to challenge the regrettably popular construction of self-injury as a female pathology (Brickman, 2004).

In view of the methodological and theoretical limitations of previous prison-related literature on this topic, the present study aims to draw upon and integrate the psychological and feminist literature on self-harm outside prison, and the sociological literature on (suicidal) self-harm in custody and the effects of imprisonment, in relation to both prisoners and staff (Cohen & Taylor, 1972; Liebling & Maruna, 2005; Sykes, 1958; Toch, 1992b; Zamble & Porporino, 1988). Although self-injury amongst prisoners may well be "a distinct phenomenon" (Liebling, 1992, p. 239; see also Ivanoff, 1992), theories and findings on self-harm in clinical and community settings can arguably contribute to our understanding of this phenomenon, both at a micro level, and at a broader societal level.

Whilst to explain the causes of self-harm in prisons is beyond the scope of this study, this research aims to develop a systemic and relational understanding of this issue, by exploring it from the perspectives of both prisoners and staff. Using a qualitative methodology and drawing upon feminist and critical phenomenological standpoints (see Ch. 2), it focuses on how staff and prisoners' experiences of self-harm are negotiated and constructed at a personal level, and influenced by the cultures, practices and regimes within and beyond the prison environment.

In considering the cultural influences that may shape and constrain staff and prisoners' experiences, particular attention is paid to gender theories and theories of masculinities. Both in prisons and outside, there has been very little emphasis on the 'fact' that "men self-harm too" (Taylor, 2003b, p. 119). The few studies that have considered male self-harm have rarely "named men as men" (Hanmer, 1990), or discussed how their being male (or their way of performing being male) may influence the meaning of their self-harm, i.e. how they themselves and others may make sense of their self-harm. Vice

versa, there has been little discussion of how being a 'self-harmer' may influence one's identity as a man.

Arguably, these questions are especially relevant in the context of prisons. As the most male-dominated of modern institutions, the male prison has been described as a "society dominated by discourses of masculinity" (Hsu, 2005, p. 1). These are likely to be centtal to the production and negotiations of both staff's and prisoners' identities, roles and hierarchies, and embedded in the daily prison practice of how staff and prisoners cope and interact with each other (see e.g. Carrabine & Longhurst, 1998). Particularly in relation to an issue as (female) gendered as repetitive non-suicidal self-injury, discourses of masculinities are likely to influence how staff and prisoners construct this behaviour, as well as their willingness to seek, receive or provide support in relation to self-harm. Despite the persistence of a macho form of managerialism (see Ch. 4), the recent (rhetorical) shift to more caring prison masculinities may also shape their perceptions and experiences of self-harm. Therefore, whilst not advocating an analysis exclusively based on gender, it may be argued that a gender-*aware* approach can significantly add to our understanding of this phenomenon.

1.8.1 Research Aims and Objectives

Given the above, this investigation aimed to:

1. Explore the expressed motivations of male prisoners who repeatedly self-harm with no apparent suicidal intent.
2. Investigate the impact of staff attitudes and staff-prisoner relationships on the welfare of adult male prisoners who repeatedly self-harm with no apparent suicidal intent.
3. Explore the views, experiences and reactions of different staff groups in relation to male repetitive, non-suicidal self-harm.
4. Increase knowledge and awareness of the effect(s) on prison staff of working with adult male prisoners who repeatedly self-harm with no apparent suicidal intent.
5. Explore the views of staff concerning how they can be most effectively supported to work with adult male prisoners who repeatedly self-harm with no suicidal intent.
6. Make relevant recommendations for policy and practice.

Additionally, a superordinate aim of this research was to increase awareness of the "hidden problem of self-harm in prisons" (Howard League, 1999, p. 1), and of the role of the criminal justice system in creating self-injury. In turn, it was hoped that this would stimulate discussion, as well as action, in relation to the functions, (over)uses and abuses of imprisonment.

Whilst I remained committed to these aims throughout the research, my understanding of how best to achieve them evolved considerably, alongside - or perhaps as a result of - my conceptualisation of issues of power, subjectivities, language, 'reality' and ideology (and their complex inter relationships). Inspired by feminist post-structuralist writings, I became increasingly aware of the need to question the assumptions and potential implications of my work. Particularly when researching a topic as "sensitive" (Renzetti & Lee, 1993) as prisoner self-harm, it is crucial to reflect on whether doing so is 'good', and for whom. These very questions were central to a significant shift in the trajectories and methods of my study and, therefore, are discussed in the following chapter.

Chapter 2: Research Praxis

> Research is an active process, engaged in by embodied subjects, with emotions and theoretical and political commitments. (Gill, 1998, p. 24)

Psychology has mainly constructed itself as a benign discipline (for a review see Lazard & Marzano, 2005). The generation and accumulation of 'scientific' knowledge of human behaviour has been largely justified, and celebrated, in terms of human and societal betterment (Gergen, 1996), arguably ignoring the question of who may actually benefit from this "regime of truth" (Foucault, 1980), and who may not (Burman et al., 1996; Henriques, Hollway, Urwin, Venn, & Walkerdine, 1998). Liberal humanistic discourses around the (human) rights of prisoners have also contributed to the perception that researching their treatment and welfare is, in Byock's (2002) words, the "right thing to do" (p. 107). Arguably, however, things are rather more complex. As discussed by Parker (2005, p. 13), "each stage in the research [...] has a moral and political dimension". Any study involving participants raises a number of ethical issues, for researchers and participants alike.

Traditional psychology has been mainly concerned with the ethics of *how* we conduct our research, often overlooking the moral and political implications of *what* we are investigating. The impression that may derive from this is that our research may be considered ethical, as long as certain well-rehearsed procedures are in place. These almost standard measures are primarily designed to protect the welfare of our participants, by regulating the collection and handling of (anonymous and confidential) data. What these fail to address, however, are the "dilemmas of representation" (Wilkinson & Kitzinger, 1996) that inevitably arise when researching the 'Other'. Even when using seemingly democratic and participatory methods, there is always a risk of "appropriation" and "exploitation" of those being studied (Burman, 1997; Opie, 1992; Reay, 1996). Also traditionally neglected are the well-being of researchers themselves, and the potential implications of how we (mis)represent the work of other researchers in our field.

Whilst investigating prisoner self-harm (or any other topic) may not be intrinsically 'good' or 'bad', the way in which this topic is conceptualised *and* approached has

important implications. Arguably, the question is not *whether* researching this topic is good, but rather *when*, and for *whom*.

This chapter aims to show how these very questions - and the "emotions and theoretical and political commitments" (Gill, 1998, p. 24) behind them - have shaped this research. It does so by following a loosely chronological order: starting from the original designing of the research, to the conduct and analysis of the interviews, and the presentation of data. The main tensions encountered as the research evolved and developed are considered, together with the theoretical, ethical and pragmatic considerations that have contributed to both defining and resolving these challenges.

The title "research praxis", borrowed from Stanley (1990), was chosen for two main reasons. Firstly, to celebrate and position myself within a tradition of feminist research that has rejected the notion of value-free science, in favour of that of "reflexive" (Freshwater, 2002), "democratic" (Hollway, 1989) and "passionate inquiry" (Raymond, 1986). In the words of Stanley (1990), the word "praxis" is "an indication of a continuing shared feminist commitment to a political position in which 'knowledge' is not simply defined as 'knowledge *what*' but also as 'knowledge *for*'" (p. 15).

Secondly, this term is used to acknowledge "the circular relation between method and theory, that is how method has an effect on the production of knowledge and vice versa" (Hollway, 1989, p. 17). Questions of method are often discussed as "relatively insignificant matters" (Stanley, 1990, p. 15), that can be settled *ad hoc*, and that serve to produce or discover an accurate picture (or *the* accurate picture) of the phenomenon being investigated (see e.g. Schwalbe & Wolkomir, 2001). However, "'how' and 'what' [we research] are indissolubly interconnected" (Stanley, 1990, p. 15). For this reason, this chapter has not adopted positivist conventions of separate theory, methods and methodology sections. Nor does it separate discussion of ethics or reflexivity, as I believe that these do - and should - permeate this whole chapter, and thesis.

2.1 Researching Self-Harm in Prisons: Changing trajectories

When I started researching this area, I was particularly interested in the notion of self-harm as an expressive behaviour, which functions (primarily) to release tension caused by

the suppression of feelings (e.g. Arnold & Magill, 1996; Pembroke, 1998). In turn, this may be seen to suggest that poor levels of self-disclosure and emotional openness, though not necessarily a *cause* of self-harm, may well be associated with this phenomenon. To test this hypothesis, I designed a large-scale questionnaire study to measure the styles of communication and self-expression of prisoners who self-harm, and compare them to those of a matched control group that did not. This would have been an enhancement and replication of a study carried out as part of my undergraduate degree (Marzano, 2001). It would have formed the largest part of my research, with a subsidiary line of investigation being concerned with the views and training needs of staff dealing with prisoners who self-injure.

What I had not considered was that focusing on the communication skills of "vulnerable" prisoners (Liebling, 1995) was neither practical nor emancipatory, on a number of levels. Firstly, having to control for the numerous risk factors that are thought to be associated with self-harm, would have meant involving a very large number of participants, in turn causing excessive intrusion in prison life. Perhaps more importantly, imposing a quantitative and deductive structure to the study of self-harm may be argued to restrict both theory development and participants' 'voices'. A more empowering and fruitful approach could be to allow those being studied to describe their own experiences and interpretations, in their own words. From a critical phenomenological perspective (Maeve, 1997; Spiegelberg, 1940), a qualitative approach aimed at exploring and "describing the insider view" (Blaikie, 1993, p. 176) is not only more democratic, but also more appropriate for trying to understand the complexity, uniqueness and variety of human ("lived") experience, and the ways in which this is expressed and constituted (Tappan, 1997).

Setting aside the so-called quantitative versus qualitative debate (Bryman, 1988; Jayaratne & Stewart, 1991), investigating the communication and/or coping skills of those who self-harm runs the additional risk of obscuring the role of the system in creating self-injury. In so doing, it may reinforce the questionable assumption of a unitary rational subject (Henriques et al., 1998), and the stigmatising contention that *they* (rather than the system) are "poor copers" (Toch, Adams, & Grant, 1989). Arguably, self-harming is not a state, trait or illness of particular individuals, but a complex phenomenon

resulting from the dynamic interactions between individuals and their environments. As all "human behaviour", it may be more usefully conceptualised as:

> a relational phenomenon, involving the intermingling of bodies and consciousness in actions that performatively institute ways of being and doing, that is to say, that performatively produce particular identities and subjectivities. (Henriques et al., 1998, p. xv)

Therefore, "developing situated knowledges from multiple standpoints" (Jackson, 1998, p. 62), and exploring the psycho-social and cultural dimensions to self-harm in prisons, may be more useful in understanding this issue than simply concentrating on 'individual differences' (read deficiencies). For this very reason, the research design was shifted further towards the lives and experiences of prison staff. As discussed in the previous chapter, their responses to self-harm have important implications for prisoners who self-injure, as well as for staff themselves, and, potentially, for the prison regime.

Furthermore, if self-harm is - amongst other things - a form of communication and self-expression, it could be suggested that prison staff can make the single most important contribution to the prevention and management of a prisoner's self-injury by "discussing the inmate's problems, concerns and anxiety" (Pannell et al., 2003, pp. 103-104), and creating a supportive environment in which prisoners might not feel compelled to express themselves through self-harm (see e.g. HMCIP, 1999). Clearly, "staff are an essential component in the exploration of suicide and deliberate self-harm in prisons" (Liebling, 1992, p. 195).

With hindsight, when I first decided to involve staff in the research, I was perhaps more concerned with testing and exposing their presumed negative views, than listening to them. The literature is rife with examples of workers being hostile and punitive towards people who self-harm, both in prisons and outside (see Ch. 3 and 4), so I was keen to collect data that would 'prove' the need for better staff training, in the interest of prisoners who self-injure. Shifting the gaze to the relatively more powerful also meant diverting attention away from prisoners as the problem to be addressed, and encouraging services to examine themselves (Burman & Chantler, 2003). With time, however, I became increasingly more aware of the issues and concerns of staff themselves, and of

the need to acknowledge and explore their experiences, more broadly and maybe more independently.

Perhaps even more so than prisoners themselves, staff have arguably been denied a voice in relation to self-harm and prisons research in general. Therefore, one of my research aims became to provide more information about the quality and nature of their jobs and to do so in a manner that enhances our understanding of the prison regime. By increasing the involvement of staff in this research I hoped to promote prisoner and staff well-being.

Eventually staff became the main focus of the research, mainly so that the views of different staff groups could be heard. Nevertheless, prisoners remained an important part of the study. Indeed, it was following their suggestions that the staff sample was enlarged to include more doctors and nurses.

2.2 Conducting Sensitive Research

However approached, self-harm remains a sensitive and controversial area of study. Shifting the focus to staff, and staff-prisoner relationships, does not necessarily render this topic any easier, for either of these groups, nor for researchers (some additional ethical concerns that arose in relation to each of these groups are discussed in section 2.10). Indeed, it may be argued that any research carried out in a prison setting is potentially ethically concerning, because the researcher:

> is in a private place, a place where people live and work [...] His (sic) very presence is potentially intrusive and impolite - a reminder to prisoners and staff that they do not own their environment and that they can have people foisted on them whom they did not ask for. (Sparks, 1989, pp. 16-17; as quoted in Liebling, 1992, p. 119)

In relation to prisoner participants, the nature and extent of these ethical implications are also better understood in view of the overwhelmingly disadvantaged backgrounds prisoners tend to come from, and the traumatic life effects associated with "doing time" (Matthews, 1999). "Prisons collect individuals who find it difficult to cope, they collect excessive numbers of people with mental disorders, they collect individuals who have weak social supports, they collect individuals who, by any objective test, do not have rosy

prospects" (Gunn, 1994; as quoted in HMCIP, 1999, para. 3.11). Disproportionately represented in the prison population are people who have experienced multiple family breakdowns, and who are socially isolated, both outside and inside of prison (see e.g. HM Prison Service, 2001). As a result, encouraging prisoners to discuss their relationship with staff means asking them to comment on particularly sensitive areas of their lives. Sharing information of this nature may be especially distressing for prisoners who self-harm, who are seemingly more prone to have relationship and communication difficulties with fellow prisoners and staff (HMCIP, 1990, 1999), and are especially likely to be victims of bullying (Livingstone, 1997), an experience which people may be afraid or ashamed to admit, or may prefer to ignore (Loucks, 1997).

Bullying is only one of several aspects of "doing time" which prisoners may feel uncomfortable discussing. Life in prison entails an almost total loss of autonomy and privacy (Goffman, 1968; Sykes, 1958), that for many may be reminiscent of past experiences of trauma and abuse, over which they also had very limited power and control. This may be especially the case in relation to prisoners who self-harm, who are reportedly more likely to have a history of child abuse and abandonment (Livingstone, 1997). Interviewing them on their self-harming behaviour may uncover unpleasant memories, which is particularly concerning as many will have received no help or support in relation to these experiences (see e.g. Loucks, 1997). Even for those who may not have had these experiences, discussing self-harm may re-open old wounds, or highlight more recent difficulties, potentially causing participants to feel anxious, uncomfortable and distressed.

Self-harm in prisons is also a potentially sensitive topic for the staff who work with this complex behaviour, particularly as some of them may also self-injure or be close to someone who does. As discussed in more detail in Chapters 3 and 4, dealing with self-harm can raise a range of anxieties for staff, which they may feel reluctant to acknowledge even to themselves. "The staff's professional role often makes the direct expression of their emotions questionable and professionalism may prohibit such expression" (Norton & Dolan, 1995, p. 77). In the context of prisons' "blame and performance culture" (e.g. Borrill et al., 2004), and given their roles and responsibilities in relation to self-injury, staff may feel threatened when discussing this topic.

Furthermore, in light of the individualistic (Schaufeli & Peeters, 2000) and "macho" (Ryder, 1994) culture which tends to prevail in male prisons, both staff and prisoners may feel reluctant to discuss their feelings and experiences with a researcher. In this context, the "myth of the manly man" (Toch, 1992a) may compel participants to avoid, or even fear, discussing sensitive personal issues. Particularly when discussing a topic as politicised and "feminised" (Brickman, 2004) as self-injury, self-disclosure may be seen as self-incriminating *and* a sign of weakness, thus becoming a potential source of embarrassment and stigma. Whilst these issues are traditionally discussed in relation to men, there is evidence that they can also affect female members of staff (see e.g. Britton, 1997; Zupan, 1986). As commented by one of the participants in this study:

> Because it's a male, predominantly male establishment, and for a woman in a male establishment, working alongside men, they are going to look at you and think 'oh you are very weak. What are you doing this job for, if you can't cope with, with a little bit of blood here and there? [...] So it's just best to say 'yeah, I'm fine'. (Frida, officer, 476-479, 513)

2.2.1 Monitoring Ethical Practice throughout the Research Process

Nevertheless, sensitive research is not necessarily ethically unsound or damaging to participants. Indeed, there is evidence that "in many instances [...] research participants desire catharsis" (Renzetti and Lee, 1993, p. 9) and welcome the opportunity to discuss difficult feelings and emotions (for a discussion of the effects of emotional and trauma disclosure see Derlega, Metts, Petronio, & Margulis, 1993; Kovac & Range, 2002; Pennebaker, 1993; Pennebaker, Hughes, & O'Heeron, 1987), particularly with an outsider (Liebling, 1992) and a woman (Crowe, 1998; see also section 2.5.1).

In addition, as Sieber and Stanley (1988, p. 55) argue:

> Sensitive research addresses some of society's most pressing social issues and policy questions. Although ignoring the ethical issues is not a responsible approach to science, shying away from controversial topics, simply because they are controversial, is also an avoidance of responsibility.

Avoiding discussion of private and emotional issues is not a solution to the ethical difficulties raised by sensitive research. Instead, one may more carefully evaluate the conduct of research (Renzetti and Lee, 1993), and constantly monitor its impact on participants.

Self-harm in prison is a very sensitive topic, but one that needs to be investigated. A number of steps were therefore taken to ensure that I remained ethically responsible throughout the research, i.e. when designing, negotiating and conducting the research, as well as analysing and disseminating its 'findings'. It is to each of these stages of research that the chapter now turns.

2.3 Designing the Studies

As contended by Sieber (1993), one of the first steps in conducting ethically sound research is to employ appropriate techniques of data collection, to "learn the perspectives of those who will be the participants and the gatekeepers of the intended research and to design the research with those perspectives in mind" (p. 17).

As already argued, a qualitative method seemed the most appropriate to explore the views of both prisoners and staff, as it would allow me do so in a less structured and inductive way. In particular, and amongst other qualitative techniques, semi-structured interviews appeared to offer the most useful, practical and flexible tool to address the research questions delineated in Chapter 1. Whilst certainly not immune from criticism (see e.g. Hepburn & Potter, 2003), interviews remain an "ubiquitous feature of the social scientific project" (Redley, 2003, p. 350). In the words of Banister, Burman, Parker, Taylor and Tindall (1994, pp. 50-51), they can "document perspectives not usually represented" and ultimately "empower disadvantaged groups by validating and publicising their views". In the context of prisons, interviews carry the additional advantage of not requiring a written response. Interviews effectively include the large percentage of prisoners who have poor literacy skills (see e.g. National Literacy Trust, 2007), as well as encouraging staff to participate. Having to provide a written response (as, for instance, required by self-completion questionnaires) may be perceived by prison staff as being time consuming and/or may remind them of the many forms they often (reluctantly) complete as part of their daily duties (Safer Custody Group, personal communication, 14th August, 2003).

In consultation with the Safer Custody Group, two interview studies (carried out in parallel) were devised. The first involved 20 male prisoners with a history of repetitive, non-suicidal self-harm. The second was carried out with 38 members of staff from the same establishment, including representatives of all grades, disciplines and both genders. For each of these studies, I designed a semi-structured interview schedule (see sections 2.8 and 2.9, and appendices 3c,d,e and 4c), which I hoped would engage with previous studies, address my research questions, and allow participants to raise some of their own issues and concerns.

2.4 Negotiating Access to Participants

Having designed the interview schedules and procedures to be employed in each study, the process leading up to the interviews was long and complex. The road to conducting research in prisons, particularly on such a sensitive area, is filled with challenges and red tape (see also Patenaude, 2004). Given the topic and populations being investigated, these are important (if time-consuming) safeguards, for researchers and participants alike. As an independent researcher, I retained considerable control over many aspects of the study, although I was monitored and guided by two supervisors, an Ethics committee, the Safer Custody Group, the NOMS Applied Psychology Group, the Suicide Prevention Team of the prison where the research was conducted, and, but perhaps less directly, by the Economic and Social Research Council (ESRC), who funded the project.

Ethical approval was sought from the Psychology Ethics Committee at Middlesex University (see appendix 2), and from the NOMS Applied Psychology Group (see appendices 1a and 1b). The latter was not only strictly concerned with "research ethics", but also with the "potential benefits of the research to the Prison Service", its "resource implications for Prison Service Headquarters", and issues of "internal and external validity". In compliance with the University's regulations, a risk (and precautions) assessment of the proposed fieldwork was also carried out (see appendix 2) (followed by an even more thorough one conducted to satisfy maternal concerns). The prospect of me, as a young woman, walking around a male prison *and* carrying keys to its main internal

gates[5], raised a few eyebrows and anxieties - including, occasionally, my own (see also section 2.5.1). Somehow, reassuring myself and others that I would be wearing a whistle at all times did not always go very far in settling these fears.

In consultation with the Safer Custody Group, it was decided that participants should be recruited from a local male prison (please see below). After failed attempts to access two prisons, the Governing Governor of a local prison in the South East of England eventually agreed for the research to be carried out at his establishment (please see an anonymised recruitment letter in appendix 1c). This cannot be named or described in detail, to protect the participants' anonymity. However, it is important to provide some contextual information about the timing and location of the research.

2.5 Contextualising the Research: Location and timing of the fieldwork

The research was conducted at a very large and overcrowded establishment. Like all local prisons, the establishment in question deals with male adults and young offenders (aged between 18 and 21) who are sent directly from the courts in its catchment area, either when remanded in custody before trial, or after conviction or being given a sentence. Local prisons can hold prisoners for the duration of their sentences, or only for the initial assessment and classification of convicted prisoners before their allocation to another establishment. By their very nature, they hold a transient and varied population, at a time for many of heightened uncertainty and stress (see e.g. Bukstel & Kilmann, 1980). Higher than average levels of overcrowding also mean that local prisons tend to offer "more limited regimes and more limited opportunities for staff to form relationships with prisoners" (Howard League, 2001, p. 4). Possibly due to these very reasons, they tend to have a "significantly higher" rate of self-inflicted deaths and self-harm than other types of establishments (HMCIP, 1999, p. 49). The establishment in question was no exception, both in terms of poor conditions and high rates of suicide and self-harm.

The research was conducted between July 2005 and January 2006. According to the prison's bulletin (October 2005), this was a "critical" time of change and "incredible pressure". An old Victorian, state-run prison, it had only recently - and narrowly - passed

[5] For an interesting discussion of issues related to carrying keys in prison research see Mills (2004).

a Performance Test (see glossary). With a few exceptions, this was described by staff at the establishment as an exhausting process of having "to bid for our own job" (Bernie, officer, 46), and one of the main causes of the low staff morale of which many spoke. Despite having been granted a five year Service Level Agreement (see glossary), the prison remained (and remains) under constant threat of being privatised, with the additional difficulty of having spent "all the money [...] to win the bid" (Prison Bulletin, October 2005). During the time of my fieldwork, staff were preparing for a Performance Test re-evaluation, a Security Audit, and various self-audits (arguably at the expense of other, less tangible priorities), whilst trying to make budgetary savings to overcome this "unpredicted financial disaster" (*Ibid.*, August 2005). In turn, these were said to have rendered the regime delivery (even more) "sporadic and unpredictable" (*Ibid.)*, to the frustration of both prisoners and staff. Also heterogeneous were the ethos, relationships and practices in different parts of the prison, with many commenting that its four main units run relatively independently.

At a time of change for the whole prison system with the creation of NOMS, this particular establishment faced the added pressure and uncertainty of drastic changes in senior management. These, however, were described by many as positive, as was the progress the prison seemed to be slowly making. For example, its physical condition was being extensively refurbished and modernised, including in areas thought to make local prisons "safer" (see HM Prison Service, 2001; Liebling, Tait, et al., 2005). On a more general level, and not long after the end of the fieldwork, the establishment was described by the then Chief Inspector of Prisons (reference withheld to protect participant anonymity) as "an improving prison, but one which has a significant way to go before it is a good and well-performing prison, on any of our four tests of safety, respect, purposeful activity and resettlement".

"Suicide [and self-harm] prevention" was also an area "where more attention was needed" (*Ibid.*). In the year prior to the research there had been approximately 180 recorded incidents of self-harm and four self-inflected deaths, two of which were being investigated at the time of the fieldwork. Such inquests are known to have important implications for staff morale (see e.g. Borrill et al., 2004), and are likely to have affected the research. At a time of potential blame and accusation (as well as repeated testing and

disappointing "suicide prevention and ACCT procedures" audits and self-audits), staff may have felt particularly reluctant to discuss issues around suicide and self-harm. This may be especially the case as the ACCT strategy had only recently been introduced and many had yet to receive any training in relation to the new system, or indeed the old one.

2.5.1 'Doing Time' at the Prison: Being in the field (and outside)

On the whole, and considering the generally low morale of staff and prisoners at the establishment, both seemed to respond quite positively to my presence in the prison and, but perhaps less so, to my research. Whilst others have discussed the "distrust" "inmates, correctional staff and administration, share [...] for outside researchers" (Patenaude, 2004, p. 71S), I found all three of these groups to be quite helpful and open. For example, and despite one manager's concern that I might be an undercover journalist, I was invited to attend the monthly suicide prevention team meetings, provided with the establishment's 'self-harm statistics' and encouraged to sit on two ACCT review panels (see glossary).

This - perhaps unjustified - level of openness and trust has often been discussed in relation to the "gender politics" of conducting prison research (see e.g. Gelsthorpe & Morris, 1988; Liebling, 1992; Rivlin, 2006). Amongst others, Walford (1994, p. 224) has argued that "female researchers may be at an advantage in being perceived as being 'harmless', especially if they are relatively young and not in senior positions within their organisations". Whether this is always an advantage, however, remains open to discussion. Being perceived as a "non-threatening outsider" (Liebling, 1992, p. 120) may encourage self-disclosure and "confession" (Crowe, 1998), but does little to reassure participants that their concerns will be appropriately followed up, or to challenge those in more powerful positions to "examine themselves and their perceptions of gaps in services" (Burman & Chanter, 2003, p. 305). Being a good listener does not mean being *listened to*, with implications for researchers, as well as participants. The credibility and potential outcomes of my work were sometimes called into question, albeit implicitly. Being asked on a few occasions whether I would receive a "B" for my "little school project" was demoralising and frustrating, almost as much as the many - "neo paternalistic" (Bowersox, 1981) - comments I heard about my young age, what I should

or should not wear in the prison, and what level of sexual harassment by known sex offenders was considered "understandable" (and thus justified) by some male officers.

Nor did these issues only come to the fore when I was *in* the field. Over the years, many have seemed amused and bemused by my choice of research. Family members, colleagues and even complete strangers have felt entitled to express a (negative) opinion or make a joke about the risks I incur as a 'pretty girl' (both sexually and because of my perceived gullibility), whether I should 'care' about 'criminals' (and good riddance if they kill themselves), or indeed focus on something more cheerful. This suspiciousness would often only increase if I also 'came out' to people as a feminist (Adams et al., 2007), making my project the ultimate 'conversation killer'. In some academic and Prison Service circles, the relevance and credibility of my research were further called into question, this time on the grounds of it being a qualitative study, and thus, for some, "quick and dirty research"[6]. Perhaps, this might have been less of an issue had I been attached to an older, and more prestigious university.

Inevitably, these reactions, and the ways in which I negotiated, resisted and at times (wittingly or unwittingly) reinforced them, will have affected my research, and the fieldwork process (see Harding, 1991). Nor were these the only influences on my interactions with staff and prisoners. Both researchers and participants are "embodied subjects" (Gill, 1998), inevitably "situated in multiple different positions with respect particularly to class, education, race, age and gender" (Willott, 1998, p. 175). As a White young woman, educated, middle class, 'free', able-bodied and not a 'self-harmer' (or at least not according to the narrow definitions of self-harm which are dominant in Western culture), the power dynamics between myself and participants were complex and contradictory, often shifting within a particular interview encounter, as well as across different interviews or different types of interviews.

Nevertheless, in recounting the research process and experience it might be useful to organise these complex dynamics, by participant group. My experiences of interacting

[6] Whilst conducting the research, I attended regular "research and practice meetings" organised by the Safer Custody Group. Although I greatly enjoyed the opportunity to meet researchers and practitioners in my field, on a few occasions I felt rather disheartened by the suggestion that qualitative research is not 'proper' research (unlike large-scale quantitative studies).

with staff and prisoners were quite different, as was the focus of my interviews with each of these groups. For this reason, the recruitment and interviewing of staff and prisoners are considered separately.

2.6 Recruiting Staff

Whilst building a rapport with prisoners is almost impossible in a place where many of them are locked up for 23 hours a day, I spent a considerable amount of time getting to know and informally conversing with staff on the wings. Their general friendliness, however, did not necessarily reflect in a willingness to take part in the research.

Staff recruitment was opportunistic, and largely made by a process of refusal. Officers, healthcare and specialist staff from all grades, locations within the prison, minority ethnic groups and both genders, were approached and invited to take part in an interview about their issues, needs and concerns about working with prisoners who repeatedly self-harm. Given that "shift patterns and work commitments in prison render any notion of selecting prison officers [and other prison staff] for pre-arranged interviews wholly unrealistic" (Liebling, 1992, p. 133), I approached them in a direct and informal way, for instance by discussing the research with small numbers of staff in the center office of a wing. Information about the study was also posted on the prison bulletin, together with an invitation to take part (see appendix 3a).

To my disappointment, only one person responded to this advert, and many more refused to be interviewed, particularly in specific locations within the prison and amongst healthcare staff. Whilst some explained to me that "nurses don't do interviews", others declined, at times abruptly, on the basis of not being "permanent", not wanting to talk about self-harm and/or for reasons of confidentiality. Time was also a recurrent concern, so much so that I eventually had to cut down my interview schedule with healthcare staff, to cause less disruption to interviewees and those left behind to cover their absence. As a result of these difficulties, and whilst trying to remain friendly and empathetic, I occasionally felt rather disheartened, and concerned about the possible lack of representativeness of the resulting sample. I would have particularly liked to have interviewed more bank and agency staff, who I was told represented as much as 80% of

the healthcare staff working at the prison. Due to these difficulties, however, only a quarter of the sample were not permanent members of staff (see table 2 below).

Relations with some officers and specialists were also difficult, particularly when these were acting as gatekeepers to prisoner interviewees (rather than as participants themselves). This was often when staff of all grades and disciplines were most negative and colourful in describing prisoners in general, and 'self-harmers' in particular. In addition, and especially on one particular unit, officers were quite suspicious of the research, negative about its potential outcomes, and blasé about my personal safety. Indeed, my safety was often quite poorly monitored by staff during the interviews with prisoners (e.g. I was occasionally allocated unsuitable rooms, including one with a WC right in the middle of it and another infested by pigeons). On one occasion, I was actively encouraged by a male officer to interview a prisoner who had been classified as a "danger to women". On another, having reported my concerns about a prisoner's welfare to a member of staff, I was accused of having caused his suicidal thoughts, by asking him about self-harm (the ethical implications of this are discussed more carefully in section 2.10.3). What was possibly even more worrying and infuriating was the impression that the officer did not fully believe me and/or share in my concerns for the prisoner's welfare.

2.6.1 Staff Participants

Despite these tensions, and the relative lack of 'volunteers', not one specialist and only a few officers declined - when approached personally - to take part in the study. Officer participants were especially generous with their time, with some offering to be interviewed during their lunch break and/or after work. Eventually, a total of 38 members of staff agreed to be interviewed. This included 15 officers, 15 healthcare staff and eight specialists. Details of their personal and professional backgrounds are presented below (please see glossary for definitions and further descriptions of professional roles). Please note that all names have been changed to protect participants' anonymity.

Table 1. Descriptive Characteristics of Officer Participants

Officers	Grade	Gender	Age	Length of Service in the Prison Service
Ann	Officer	F	32	18 months
Bernie	Officer	M	39	15 years
Carol	Senior/Principal Officer	F	31	8 years
David	Senior/Principal Officer	M	37	13 years
Erik	Officer	M	28	1 year
Frida	Officer	F	33	3 years
Gavin	Officer	M	57	16 years
Harry	Officer	M	59	22 years
Ian	Officer	M	28	3 years
Jonathan	Senior/Principal Officer	M	43	16 years
Kevin	Officer	M	36	3 years
Luke	Officer	M	39	16 years
Matthew	Senior/Principal Officer	M	37	18 years
Norma	Officer	F	31	4 years
Olivia	Officer	F	39	12 years

Please note that one officer participant was a principal officer, and three were senior officers. This information is presented in a collapsed form, to protect participant anonymity. For the same reason, details of participants' ethnicity were not included in table 1 (or in tables 2 and 3 below). With the exception of two officers who described themselves as "Black", all others in the sample were "White".

Table 2. Descriptive Characteristics of Healthcare Staff (HC) Participants

Healthcare Staff	Gender	Age	Length of Service in HC Role	Length of Service at the Prison
Anthony	M	27	5 years	*
Catherine	F	37	20 years	10 months
Darren	M	41	9 years	1 year
Ed	M	43	20 years	7 years
Fay	F	32	7 years	2 years
Gareth	M	30	5 years	5 years
Hazel	F	44	20 years	1 year
Isabel	F	*	30 years	10 years
Jane	F	40+	22 years	6 years
Ken	M	*	10 years	2 years
Lee	M	45	20 years	5 years
Maria	F	48	15+ years	4 years
Nathan	M	37	16 years	3 and ½ years
Oscar	M	49	7 years	1 year
Peter	M	48	23 years	3 years

* Missing data

Four of the healthcare staff interviewed were general nurses, six were mental health nurses, two were substance misuse nurses, one was a substance misuse and mental health nurse, and two were doctors. Four of these were bank staff, and the remaining 11 were permanent members of staff (of which two were appointed on a part-time basis). In this case, only three interviewees were "White", one "Asian", and all others "Black". This was seemingly representative of the ethnic make up of the healthcare staff working at the prison (see Ch. 9.2.1).

Table 3. Descriptive Characteristics of Specialist Participants

Specialist Staff	Age	Gender	Length of Service in the Prison Service
Anita	32	F	5 years
Ben	*	M	*
Craig	62	M	30 years
Daniel	37	M	15 years
Enid	34	F	10 years
Frank	43	M	20 years
Gail	*	F	5 years
Hillary	55	F	21 years

* Missing data

Please note that information about each specialist's role, length of service at the prison, and ethnicity was withheld to protect participant anonymity. Interviewees in this group had worked at the research establishment from as little as two months to a maximum of eight years, and included: the Governing Governor, Safer Custody Governor and Suicide Prevention Co-ordinator, as well as members of the prison In-Reach Team, Psychology, Chaplaincy, the Staff Care and Welfare Service and the local Care Team (see glossary). Six of the specialists interviewed described themselves as "White", one as "Black", and one as "Asian".

2.7 Identifying and Recruiting Prisoner Participants

The process of recruiting prisoner participants was relatively straightforward. Potential interviewees were approached by an officer (and, in some cases, myself) with an information sheet about the research (see appendix 4a). This described the main purpose of the study, and explained what their participation would involve. Apart from three prisoners, all of those who were approached agreed to take part. Either immediately or at a later time (depending on work and other commitments) they were escorted to an interview room, where I provided more information and answered any questions they may have had about the study.

What was more complicated was the process of identifying such prisoners in the first place. Selecting prisoners who had a) repeatedly self-harmed and b) done so with no *apparent* suicidal intent was far from straightforward. I had envisaged difficulties in relation to the second point. Even though staff on the wings were to be consulted on this matter, I expected that in many cases decisions about suicidal intent would have to be made post hoc. What I had not anticipated were problems in identifying men who had repeatedly self-harmed. Although there are no clear or agreed definitions for 'repetitive' self-harm, in prison an incident of self-injury is considered to be repetitive when occurring within two months of the last one. Therefore, I had originally intended to *only* interview prisoners who had self-harmed at least twice in the two months prior to the data collection. Data made available by the Suicide Prevention Team at the establishment allowed me to identify the most 'prolific self-harmers' in the prison, many of whom had already come to my attention through informal discussions with staff.

However, partly because the population at the prison was so transient, there were not enough prisoners fitting this criterion for my target of 20 interviews. Therefore, I extended my criteria to prisoners with a *history* of repetitive self-harm. By doing so, I would also be able to collect data in relation to *stopping* self-injurious behaviours, which many staff had described as "impossible". To this aim, a list of potential interviewees was made available by the psychology department at the establishment. This included a dozen men known to them through "crisis counselling" or their weekly "self-harm group".

As this list included some men whom I had already interviewed, I also decided to approach prisoners who were currently "on an ACCT"[7], many of whom may have had a history of repetitive self-harm. This information can be rather difficult to establish, even by consulting the prisoner's files or staff on the wings. Indeed, asking the latter would often complicate things even further, as my definitions of self-harm and repetitive self-harm often differed from staff's. Many of the prisoners I was interested in interviewing were dismissed by officers as not being 'real self-harmers' and/or not someone I would want to speak to because of their being "difficult", "mad" or, more often, a "pain in the arse". Unless the prisoner in question was considered to pose a danger to my personal

[7] In prison jargon, this expression is used to denote prisoners deemed to be "at risk" of suicide and self-harm.

safety, these comments were ignored, and the individual approached as a potential interviewee.

I knew this strategy could have been overly inclusive, as participants could have included prisoners who did not or had never self-harmed, let alone repeatedly. At the time, I reasoned that, should that be the case, I could always exclude their data after the interview, as I would if their self-harm was not 'non-suicidal'. Only once did this situation arise, in relation to Jack. Although he had not self-harmed "yet", he had repeatedly expressed the "urge" to do so, often triggered by what he described as negative staff attitudes and responses. After careful consideration, I decided it would be unethical to exclude his voice, and counterproductive given its pertinence to the study. Similar decisions had to be made in two more cases, as the suicidal intentions of the prisoners in question were unclear and seemingly ambivalent. I again opted to include their voices, particularly as these less clear-cut cases have often been excluded by previous studies in this area (e.g. Snow, 2002a). Nevertheless, should readers disagree with my decision and prefer to disregard these data, table 4 below includes details of participants' presumed intentions, alongside their demographic and offence-related characteristics.

Table 4. Descriptive Characteristics of Prisoner Participants (continued on the next page)

	Age	Ethnicity	Marital Status	Status	Sentence Length	Index Offence	First Sentence	Information about ACCT Status and Self-Harm History
Andrew	34	White	*	Sentenced	6 years	Wounding with intent	*	On ACCT at the time of the interview. Reported having stopped self-harming, but subsequently started to do so again.
Bill	27	White	Single	Sentenced	* (Release imminent)	Theft	No	On ACCT at the time of the interview. Singled out by various members of staff as a very "prolific self-harmer".
Carl	*	Black (Foreign National)	*	Sentenced expired Awaiting deportation	* (Release imminent)	Reported consenting sex with a minor (prison file not available)	Yes	On ACCT at the time of the interview. Suicidal intentions unclear.
Donald	26	White	Single	Sentenced	16 months	Theft	No	On ACCT at the time of the interview.
Ethan	42	White	*	Sentenced	30 months	Multiple offences against property	No	On ACCT at the time of the interview.
Fred	26	White	Single	Sentenced	16 month	Breach restraining order	No	On ACCT at the time of the interview.
George	36	White	Divorced	Remand	N/A	Wounding with intent to kill	No	History of self-harm, but no longer on ACCT at the time of the interview.
Harold	22	White	Married	Remand	N/A	Theft	No	On ACCT at the time of the interview.
Isaac	30	White	Cohabiting	Sentenced	1 year	Handling with intent to supply drugs	Yes	On ACCT at the time of the interview. Self-harmed for the first time in custody
Jack	26	White	Married	Remand	N/A	Possession with intent to supply drugs	Yes	Recent thoughts of self-harming, but no history of self-harm.
Kieran	29	White	Single	Remand	N/A	Theft	No	On ACCT at the time of the interview. Suicidal intentions unclear
Leo	36	White	Married	Recalled	N/A	Theft (whilst on licence)	No	On ACCT at the time of the interview.

Table 4 (Continued). Descriptive Characteristics of Prisoner Participants

	Age	Ethnicity	Marital Status	Status	Sentence Length	Index Offence	First Sentence	Information about ACCT Status and Self-Harm History
Mark	31	White (Foreign National)	*	Detainee	N/A	Illegal immigrant	No	On ACCT at the time of the interview.
Nick	31	Asian (Foreign National)	Cohabiting	Remand	N/A	Grievous bodily harm	No	Not on ACCT at the time of the interview. Reported history of self-harm and current thoughts of self-harming (suicidal intentions unclear)
Oliver	52	White	Single	Recalled (sentenced)	7 years 6 months	Multiple sexual offences against minors	No	On ACCT at the time of the interview.
Paul	30	White (Foreign National)	Cohabiting	Remand	N/A	Theft	*	On ACCT at the time of the interview.
Quentin	33	White	Cohabiting	Sentenced	9 months (Release imminent)	Breach of sex offender order	No	History of self-harm, but no longer on ACCT at the time of the interview.
Richard	24	White	Single	Convicted Awaiting sentence	N/A	Rape	No	On ACCT at the time of the interview.
Stephen	33	White	Single	Sentenced	30 months	Conspiracy to indecent assault	No	History of self-harm, but no longer on ACCT at the time of the interview.
Tom	37	White	*	Sentenced	4 years	*	No	On ACCT at the time of the interview.

* Missing data

Please note that all prisoner participants had been in custody for at least 6 weeks at the time of the interview. Five had been arrested on sex related charges, four for (physical) violence against the person, eight for theft and handling, and one for criminal damage. Details of one

participant's index offence were missing, whilst another was classified as a detainee. Aside from the latter, 11 interviewees had been sentenced, one was convicted but unsentenced, and seven were on remand.

Whilst the ethnic make up of the sample was more or less representative of the prison population, and of individuals who self-harm (in custody and outside), participants' ages were considerably higher than those of people traditionally over-represented in self-harm statistics, both inside and outside of prisons (see e.g. Meltzer et al., 2002; Safer Custody Group, 2007). Less than half the men in the sample were under the age of 30, which was recently identified as an approximate cut-off point for decreased risk of self-harm (see Safer Custody Group, 2007). Whether or not this may be attributed to chance (age had not been a selection criterion for participation in this study), it clearly reinforces the need to increase awareness and understanding of self-harm amongst men of all ages, rather than only focusing on young adults and adolescents (see also Ch. 1.3.8).

2.8 Prisoners' Interview Schedule

Many of the questions included in the interview schedule for the prisoner study (see appendix 4c) were adapted from those used in my undergraduate research, and the ones subsequently developed to be employed in a large-scale questionnaire study on the relationship between emotional disclosure and self-harming behaviour (see section 2.1). Both of these had been designed to elicit prisoners' perceptions of their styles of coping and self-expression, and their relationships with fellow prisoners and staff, as well as friends and family outside the prison. The latter questionnaire also included questions about participants' personal and familial backgrounds, with further items addressing the history and meanings of their self-harming behaviour, and their needs and preferences for support.

Both scales had been developed following an extensive review of the literature, discussed at length with my supervisors and the Safer Custody Group, and approved by the Psychology Ethics Committee at Middlesex University. The first had been successfully employed in structured, face-to-face interviews with 40 adult male prisoners, whilst the latter, more extensive questionnaire had been piloted as a self-completion questionnaire

with a sample of 55 undergraduate students at Middlesex University. Therefore, it seemed appropriate to retain some of the focus and the ordering of these questions, but to re-word them in a more open-ended manner, and to do so in a way that would minimise participants' potential discomfort at discussing sensitive matters in a face-to-face situation. To this end, considerable time was spent researching examples of semi-structured interview schedules used in sensitive and prison-based research.

This process, along with a review of the relevant literature, also helped to identify, formulate and organise further questions to include in the final interview schedule. Reflecting the shift in focus of the current research, questions were added about participants' experiences of being in prison, and their interactions with staff. The interview guide also aimed to investigate the effects of staff's attitudes and reactions to self-harm on the quality of staff-prisoner relationships, and their potential implications for rates of suicide and self-harm in custody.

2.9 Staff's Interview Schedules

The background research that guided the development of the interview schedule for the prisoner study also helped to identify questions and topics to incorporate in the interviews with staff (see appendices 3c,d,e), and to formulate these in a clear and sensitive manner. For both ethical and theoretical reasons, and to promote a good interview interaction, it was important that the staff interview schedule would reflect my interest in their own experiences and welfare (as well as those of prisoners). The first part of the interview guide was therefore designed to elicit participants' views of the quality and nature of their jobs. Questions around staff morale and staff-prisoner relations were also included in this section, but worded so that participants could provide collective - and more impersonal - answers, rather than having to discuss their own state of mind and relationship with prisoners.

The second part of the staff interview addressed participants' views, experiences and training in dealing with prisoners who repeatedly self-harm, with no apparent suicidal intent. Questions aimed to explore how staff understood and constructed this behaviour, and the prisoners engaging in it. Further questions addressed how participants felt about

their roles and responsibilities in relation to this area of work, and aimed to elicit their knowledge and opinions of the systems and procedures involved.

The final broad topic covered by the interview schedule was designed to address some of the questions raised by my MSc project on support services for prison staff dealing with self-harm (Marzano, 2004; Marzano & Adler, 2007). In particular, questions aimed to explore how staff coped with this area of work, and their needs and preferences for support. In relation to the latter, participants were specifically asked about training, supervision, formalised post-incident interventions, and perceptions of support from colleagues and managers.

Please note that, although the basic interview schedule was very similar across staff groups, slightly different versions were developed and/or later modified, for officers, healthcare staff and specialists (see appendices 3c, 3d and 3e, respectively). For example, interviews with the latter were tailored to the particular specialism of the interviewee, and included more questions about policy and about the impact of self-harm on *other* staff.

2.10 The Interview Process

In many ways, the procedures involved in interviewing staff and prisoners were very similar. Both groups of participants were interviewed in a private (or semi-private) space, often an interview room or office on the wings. These are equipped with 'panic buttons' and a glass window which permits others to see inside the room, without (ideally) hearing what is being said or having to open the door. Interviews were audio-taped and lasted between 30 and 90 minutes. Before they were carried out, care was taken to explain to participants the purposes, methods, and uses of the research, and to assure them that their answers would remain confidential, within the limits imposed by the law. Prisoners were specifically advised that should they reveal the intention to 'seriously' harm themselves (or others), a member of staff would have to be alerted - with the participant's knowledge, but, if necessary, without his consent. However, "the information disclosed [would] be sufficient to allow those attempting to protect the participant to do so in a properly informed manner, but matters not relevant to the suicidal state may not need to be divulged" (Francis, 1999, p. 219).

The voluntary nature of their participation was also emphasised, as was their right to stop the interview at any time, and to refuse to answer any of the questions. These points were further elucidated in a consent sheet, which they were asked to read and sign prior to the interview taking place (see appendices 3b and 4b).

During the interviews, I aimed to be (or at least *appear* to be) empathetic and non-judgmental, and to encourage participants' self-disclosure, whilst trying to minimise their distress. Although I followed - more or less loosely - my interview schedules, virtually all of the questions posed were open-ended. Furthermore, at the end of the interview, participants were asked if they had anything else they would like to ask or add. Often, and particularly with staff, this sparked off a more informal conversation about the issues at hand. With hindsight, this also became a welcomed opportunity to step out of the interviewer role, and be more open about my own views and/or about challenging theirs. Whilst I was mindful of having asked people to share their views, rather than to be confronted about them, I reasoned that to do so - with tact - and to express my own opinions and agenda, could sometimes be both appropriate and ethical. This was especially the case as I knew that I would not have the time or opportunity to meet them again for a "collective discourse analysis" (Willig, 1999a).

At the end of the interview or of this more informal discussion, participants were fully debriefed, and hence provided with "any necessary information to complete their understanding of the nature of the research" (British Psychological Society, 2000, p. 8; see also British Psychological Society, 2006). As part of their debriefing, they were also provided with an information sheet with details of various sources of advice and support (see appendices 3f and 4d), and informed that, in due time, a summary of key findings would be sent to each wing, together with a copy of the final report.

2.10.1 Interviewing Staff: Tensions and resistances

Despite employing similar procedures, the interviews with staff seemed to raise different tension and reactions than those conducted with prisoners, not only amongst the participants, but also for me as a researcher.

Often these came to the fore when asking staff about their needs and preferences for support. This was frequently the most difficult part of the interview, with many denying their need for "support", resenting being asked about it (especially as some were also managers and thus 'supporters') and occasionally laughing at some of my questions and prompts (particularly when the idea of discussing their *feelings* was mentioned). Whilst I sometimes found myself laughing along with them, I often felt rather disheartened by these reactions, partly because I anticipated some of the difficulties and complexities I would encounter when analysing these data and trying to make recommendations for practice (see Ch. 8.4). At the same time, I could not help but feel that some of this laughter may have been directed at my naivety, as a female "civilian", and psychology student, asking the sorts of questions – and using the sort of language – that did not sit well with the "traditional" prison culture (see Ch. 4.6.1). Particularly amongst uniformed staff, these questions seemed to emphasise my being an outsider, which, however, was not always a bad thing (see also section 2.5.1).

With time, I realised that the issue was not necessarily my asking staff about "support", but my doing so specifically in relation to repetitive, non-suicidal self-harm (see Ch. 8). To facilitate discussion around their needs and suggestions for support, I therefore begun to ask broader questions about the sort of help they would like for their work, in general. Although this was a useful 'ice-breaker', it remained clear that many staff were not accustomed to talking or being asked about their preferences for support, or indeed many of the issues discussed – particularly not in an interview. Being interviewed was for some an alien and even uncomfortable experience, particularly in the presence of a tape recorder. Nevertheless, and despite some participants' initial reservations, most made positive comments about taking part in the research, and being able to "say things that we don't maybe get an opportunity of saying" (Ed, healthcare staff, 638-639).

2.10.2 Interviewing Prisoners: Ethics and emotions

The process of interviewing prisoners was relatively straightforward, but not always easy. Despite repeated suggestions in the literature that asking people about their self-harm is not likely to precipitate further self-injury (e.g. Snow & Paton, 2002), it would be naïve – and dangerous - to suppose that participants may not feel upset during or following the interviews. For this reason, it was paramount to ensure that "professional

support is available, should it be needed, after the interview" (Taylor, 2003a, p. 85). To this end, as I learned during the fieldwork, conducting interviews late in the day should be avoided. This carries the danger of leaving prisoners feeling distressed, at what is already considered to be a risky time (Albanese, 1983; Gaston, 1979), and when specialist staff may have already left work.

Nevertheless, even when seemingly upset during the interviews, prisoners seemed on the whole quite comfortable and eager to discuss their feelings and experiences. Unlike staff, they were all too familiar with being interviewed. Not only are prisoners more often researched than staff, many of them will have been interviewed on a number of occasions, starting from the time of their arrest, to reception, categorisation and sentence planning (if applicable). Moreover, due to the focus of the study, many of the men interviewed were or had previously been placed "on an ACCT" and/or participated in counselling, both of which involve regular questions and discussions about many of the issues raised by the research.

Although, on the surface, most of the interviews ran relatively smoothly, "the tendency [for prison researchers] to downplay the emotional components of their research projects" (Bosworth, Campbell, Demby, Ferranti, & Santos, 2005, p. 259; see also Liebling, 1999), had left me unprepared for my own feelings about the 20 men I interviewed, and the confusing and contradictory reactions evoked by their offences and their histories. Throughout the fieldwork, I frequently felt angry, punitive, intimidated and even frightened. Often, all of these feelings would come flooding in whilst walking on the landings, or worse, interviewing participants. At the same time, I often felt sad and shocked by the accounts of their lives (inside and outside prison), and powerless at not being able to help them in more 'concrete' ways - particularly as a few of them seemed to expect me to do so. On the occasion described earlier (see section 2.6), the guilt and worry of leaving a very upset prisoner with a rather dismissive member of staff - late in the day – was something I will never forget. What followed was the longest and most restless night of my fieldwork, as well as its earliest and most apprehensive start the next day. Fortunately, I was reassured about the welfare of the prisoner concerned, who was then taken under the care of the psychology department.

Whilst I was lucky to be able to reflect on these issues with my supervisors (one of whom is a psychotherapist[8]) and friends, these emotions are bound to have affected the ways in which I interacted with these men, the knowledge produced during the interviews, as well as my interpretations and representations of participants' stories and subjectivities (see also Marzano, 2007).

2.10.3 Interviewing Prisoners and *Staff: Whose side am I on?*

For readability, interviews with prisoners and staff have been discussed separately. However, many of the tensions and dilemmas in conducting research with both of these groups seemed to arise from the simultaneity of these two studies, and the complex relationships between prisoners, staff, and myself. In other words, one of the main influences on my interactions with staff was my study with prisoners, and vice versa. Trying to explore the issue of self-harm from multiple and "reciprocal viewpoints" (Hinsby & Baker, 2004) meant that my own views of self-harm, 'self-harmers' and staff shifted quite considerably during and beyond the six months of fieldwork. For instance, I found myself regularly problematising, and then de-problematising, the responses of staff, the behaviour of prisoners, and how my allegiances with one group may affect how I perceived, and was perceived by the other. I often wondered whether it was possible, and indeed desirable, to be empathetic and understanding towards both prisoners and (different types of) staff, and questioned whether my research would end up 'exposing', (dis)empowering and romanticising one group, at the expense of the other.

With hindsight, I would argue that the issue of "taking sides in research" (Liebling, 2001, p. 472; see also Patenaude, 2004) assumes and reinforces a false and forced dichotomy between prisoners and staff. In so doing, it diverts attention away from the system which (re)produces and constrains the experiences and actions of both. Nonetheless, it was, and remains difficult to escape this unhelpful dichotomy, particularly as it is implied by some of my research questions.

[8] For a discussion of the benefits of being supervised by a clinician when conducting sensitive research, and the need for a good "support structure" (James & Platzer, 1999, p. 73), see Ciclitira (1998), and Hockey (1994).

My comparing (and thus dichotomising) the views of prisoners and staff became especially evident (but arguably also useful) when analysing the data. Indeed, many of the tensions and concerns discussed so far came to the fore when summarising and interpreting interview material. As discussed in relation to the wider research process, the issue is not only *how* data is analysed, but also *what* material is selected for analysis, *why*, and with what implications. Like the development and conduct of one's study, the transcription, analysis and dissemination of data (qualitative or otherwise) is, or at least should be, guided by a number of ontological, epistemological, political and pragmatic considerations. It is to these that the discussion now turns.

2.11 Analysing the Data

My main dilemma when analysing the data was that of respecting people's experiences, whilst not "taking experience and meaning [...] at face value" (Parker, 1999, p. 26). Following the so-called "turn to language" (Potter & Wetherell, 1987), or more precisely, the turn to "discourse" in psychology (Burman & Parker, 1993; Parker, 1992), I would argue that what participants told me during the interviews was neither *the* truth nor necessarily what was "in their mind" (Willig, 2001, p. 88). As argued by Willig (1999b), amongst others, language is not reflective of reality, but constructive and performative. Nor is there a single seamless reality about self-harm, waiting to be 'discovered', but rather a multiplicity of situated and contested knowledges. Therefore, participants' views and experiences are, inevitably, *accounts* of their views and experiences, or in Shafer's (1992, p. xiv) words, "only versions of the true and the real". These are made possible by existing (but not always available) forms of language and patterns of meaning, or, in Foucault's (1969, p. 49) words, "practices that systematically form the objects of which they speak". Commonly referred to as "discourses" (*Ibid.*), these are in turn "embedded in social and political settings and used for certain purposes" (Lupton, 2003, p. 21).

It follows that rather than attempt to explain what is in participants' minds (Bordo, 1993), it is useful to explore and describe what (dominant and subjugated) discourses exist in relation to self-harm, how they are used, how they function, and, just as importantly, how they may be reproduced and resisted. This involves questioning and deconstructing "assumed truths" (Willott, 1998, p. 184), and considering "the meanings

that are created and which exist above and beyond the intentions or cognitions of the speakers and listener" (Henriques et al., 1998, p. xiii). In the words of Willig (1999a, p. 43), "the objects of research are the discourses rather than their users".

Whilst shifting the focus away from participants may, at times, feel rather convenient, the political and ethical implications of doing so cannot be ignored. Post-structuralist approaches have been criticised as disempowering, for depriving individuals of their agency and voices (see e.g. Crossley, 2000). Denying the 'reality' of participants' experiences and stories felt inappropriate, just as hiding my disapproval of some of their views behind a critique of discourses felt like an easy way out. Moreover, (over)interpreting their stories "beyond their intentions or cognitions" risks becoming antithetical to the democratic principles that informed the research, including the notion that "the researcher should not presume to know more about what the participant means" (Hollway, 1989, p. 22).

The political impetus of the research may also suffer as a result of the post-structuralist focus on fragmentation, pluralities and flux. The dangers of sliding into a 'happy relativism' have been discussed at length (see e.g. Willig, 1999b), but are by no means inevitable. Along with others, Crossley (2000) has suggested that it is possible to "find some way in which we can appreciate the linguistic and discursive structuring of human psychology without losing sight of the essentially personal, coherent and 'real' nature of individual experience and subjectivity" (p. 32).

Arguably, this possibility is afforded by a dialectical and critical realist view of the world (Parker, 1999), a perspective that "subscribes to epistemological relativism [...] [whilst it] maintains ontological realism" (Willig, 1999a, pp. 44-45). In other words, it is possible to address issues of power, language and ideology, *and* respect individual subjectivities, within a position that accepts that knowledge is inevitably located, *and* proposes the existence of some underlying, extra-discoursive realities (Burr, 1999). A critical humanist perspective (Parker, 1999) allows us to explore how experience is negotiated and constructed at a personal level, whilst drawing on available discourses, in turn historically, socially, and culturally located. In the words of Willig (1999a, p. 44),

"meanings are afforded by discourses, accommodated by social structures and changed by human actors".

In relation to one's analysis, this means that both the "modernist" and the "post-modern" tales are to be told (McAllister, 2001). According to Lather (1986), the former should be approached first, to reveal "what meanings are produced in the story" (McAllister, 2001, p. 393) told and (co)constructed (by participant and researcher – see e.g. Parker, 2005) during an interview. The analysis should then proceed to a deconstructive reading of such "standard" meanings, to bring to light tensions, inconsistencies and possibilities for change (McAllister, 2001). As argued by Parker (2005, pp. 99-100), "phenomenological immediacy" does not preclude some "theoretical distance" from those immediate meanings.

Interviews were first analysed thematically, to explore participants' views and experiences in relation to self-harm, and the culturally available discourses which shape and constrain them. When considered appropriate and relevant, data were also deconstructed drawing on the principles of discourse analysis. The main steps in these analyses are discussed below.

2.11.1 Thematic Analysis

Thematic analysis is a "coherent way of organising or reading some interview material in relation to specific research questions [...] in ways that attempt to do justice both to the elements of the research question and to the preoccupations of the interviewees" (Banister et al., 1994, p. 57). To these aims, interview data were transcribed as close to verbatim as possible. Pauses, emphasis of words, tone, volume of voice, sighs, laughter, the absence of any discernible gap at the end of a speaker's utterance, and overlaps between speakers were also noted in the notation (a copy of the transcription notation is reported in appendix 5). Please note that, for reasons of confidentiality, the completed anonymous transcripts are available only to the examiners of this thesis in two separate volumes.

Unfortunately, the quality of the transcripts was variable. Problems with the audio equipment, and the extensive (and very noisy) building work at the prison, meant that

some tapes were hard to transcribe. These difficulties were further exacerbated by my not being a native English speaker, and thus struggling to understand some regional accents. As a result, although the accounts of all participants have informed the analysis, not all are directly quoted to the same extent.

Having read and listened to each interview at least twice, both to check for accuracy and to familiarise myself with the data, I produced summaries of each transcript. These were from two to seven pages long, and incorporated selected quotes from participants, along with my interpretations, and, in some cases, relevant fieldwork notes (a sample transcript summary is included in a separate volume, available only to the examiners of this thesis). These summaries rendered more manageable the task of analysing large quantities of data, and were therefore used as a reference throughout the process of analysis. Nevertheless, I referred back to the full transcripts or tapes when further clarification was needed.

Key themes were then identified for each summary. These included recurring issues, contradictions, dilemmas and specific discourses. Such themes were then compared to the others in their group for differences and similarities, and re-analysed in light of such comparisons. To facilitate this process, some data were also presented in a tabular and/or diagrammatic form (a sample summary of themes is presented in appendix 6). Particularly when analysing the 38 transcripts from the staff interviews, this provided me with a better overview of the range of themes 'emerging' from the data, and a clearer snapshot of which of these were more or less dominant within and across each participant group.

Presenting the data in summary tables was not only intended to provide a frequency count for key themes, but also to help me maintain a focus on the accounts of individual interviewees, and an overview of 'who said what'. For every broad theme, I listed different 'versions', variations, and sub-themes, along with the name of the interviewee(s) drawing on each of these, and, occasionally, some explanatory notes. Although I did not create a separate computer file for each theme, by this point I felt very familiar with the data, and had a clear idea of which excerpts - and by whom - illustrated key themes and ideas.

Having this type of overview of the data was particularly useful when selecting extracts to include in the thesis. As well as doing so in an intuitive and "visceral" manner (Johnson, 2001, p. 112), I aimed to ensure that my chosen quotes were taken from as many interviewees as possible. Whilst it is perhaps inevitable to be especially drawn to certain forms of narrative and language, it was important that this would not result in silencing the voices of others who had not captured my attention in the same way.

The analysis of the material for all groups of participants was a long and ongoing process, possibly more so than I had anticipated. Interview data were continually examined, re-organised and 'questioned', not only in relation to other material, but also to relevant theories, research activities and, of course, my own subjectivity.

2.11.2 Discourse Analysis

An important part of this going back to, and questioning interview data, was my analysis of the discursive resources used in key excerpts. Having identified dominant, marginal and absent views, I aimed to explore how selected themes were constructed through language, and with what implications. Whilst there are at least two main approaches to discourse analysis (for a review see Hepburn & Potter, 2003; Willig, 2001), I drew primarily on the Foucauldian version (see Parker, 1992). This is especially concerned with "how texts work within sociocultural practice" (Fairclough, 1995, p. 7), at an ideological - rather than textual - level. Given the large quantities of material collected, the semantic and rhetorical structures of participants' talk informed the analysis, but were not central to it.

Although a range of systematic steps and guidelines have been outlined in the "analysis of discourse" (Burr, 1995) and "discourse dynamics" (Parker, 1992), I did not follow any prescribed formula. Drawing particularly on the work of Willig (1999b, 2001) and Parker (1992, 2005), I aimed to explore what discursive resources appeared to be available (and to whom), and how these functioned ideologically, both in terms of reproducing relations of power and of constructing subjects and objects. In other words, the main focus of my analysis was the "*explanation* of the relationship between the discursive process and the social [and institutional] process" (Fairclough, 1995, p. 97; emphasis in original). To this end, I spent considerable time reflecting on how different

people, behaviours and ideas were constructed (and by whom), what possibilities for action (and non-action) were afforded by these different constructions and "subject positions" (Davies & Harré, 1999) and, just as importantly, how these different discourses worked in relation to one another. Indeed, tracing the ways in which participants managed and negotiated potentially conflicting discourses was an especially useful tool to interpret some of the "dilemmatic" ways (Billig et al., 1988) in which different subjects and objects were constructed (see especially Ch. 8).

An equally helpful step was to continually ask myself: 'how does this discourse work?'; 'what's missing?' and - the question I perhaps most dreaded - 'so what?'. Although these questions may not allow one to speculate as to *why* a given person may have made a particular statement, they can help to deconstruct the functions and effects of their doing so. Arguably, this is a more useful and 'realistic' aim for one's analysis.

2.11.3 Analysis as 'Bricolage'

Thematic and discourse analytic approaches were combined, but not always in equal amounts. Teasing apart *all* of the discourses that may have been at work in all of the material, felt unfeasible and unnecessary. Particularly in relation to staff's and prisoners' preferences for support, participants' subjective experiences and perceptions of need were given precedence over a deconstructive analysis of the discourses which shaped them. A user-led and phenomenological approach seemed both ethical and appropriate, particularly as staff's and prisoners' views are rarely reflected in official policy, and because staff repeatedly insisted on the importance of "bottom-up" practice.

On the other hand, when analysing staff's and prisoners' constructions of self-harm it felt especially important to deconstruct and problematise "common truths" (Willott, 1998, p. 184), especially those "that hold 'true' and 'real' for our participants" (Parker, 1999, p. 34). As argued by Billig (1995), and then Parker (2005, p. 90), "dominant forms of cultural identity are kept in place precisely by the banal ways the categories are repeated in everyday discourse".

Therefore, rather than using a rigid strategy to analyse the data, I tried to be flexible and eclectic, and to employ qualitative tools and practices "as the moment demands"

(Patenaude, 2004, p. 71S). For Denzin and Lincoln (1998), a qualitative researcher is a "bricoleur", who must "work between and within competing and overlapping perspectives and paradigms" (p. 4). According to the authors, this is what "adds rigour, breadth and depth to any investigation" (*Ibid.*).

2.12 Presenting the Data

The notion of "bricolage" does not only apply to how data are analysed, but also to how they are presented. For instance, depending on one's audience(s), it may be appropriate to adopt different styles and formats. This was certainly a concern when writing data chapters - and, indeed, the whole thesis. As I drew on a range of academic and non-academic sources and discourses, and, on different 'camps' within psychology (especially feminist, clinical, critical, forensic and/or organisational approaches), I occasionally felt rather confused as to what my main readership would, or should be, and whether it excluded other potential audiences. In the end I tried to write for as wide an academic audience as possible, whilst accepting that the ways in which I decided to present and discuss data may seem contentious (but are hopefully intelligible) to those working outside critical and qualitative paradigms. A separate, more practice-oriented report will be produced for dissemination to non-academic audiences, including participants and gatekeepers.

Regardless of one's readership, it is also important to present the data in ways that will suit the type of material analysed, and one's aims for such analyses. When writing the staff data chapters, I endeavoured to discuss what discourses existed around given subjects *and* the ways in which these were drawn upon differentially by each staff group. In other words, staff data were not only analysed in relation to key themes and discourses, but also by occupational group. It was therefore important to maintain a clear focus on the accounts of each staff group, and on the differences and similarities within and across them. To this end, it seemed appropriate to first present my analysis by group (i.e. to report what themes and discourses were drawn upon by each staff group), trying to leave much of my interpretation, discussion and critique of these themes and discourses to the end of the chapter. Although this attempt to separate one's results and discussion may seem a rather unconventional way of reporting discourse analytic work, it arguably enhanced clarity and readability. Given that officers,

healthcare staff and specialists frequently drew on similar discourses (if in different ways), having a wider discussion of the implications and subject positions offered by these discourses at the end of the chapter also helped to avoid unnecessary repetition.

Data from the interviews with prisoners are instead presented in a more conventional format. Analysed as being part of one group (albeit not a homogenous one), the prisoner data are presented *and* discussed throughout the chapter, in relation to both staff data and previous psychological literature. This format avoids what is perhaps a forced and artificial distinction between one's 'findings' and interpretations.

2.13 Conclusions

Inevitably and, importantly, my own theoretical and experiential insights influenced the bricolage I produced. Political, ethical and pragmatic choices and interpretations were made at all stages of the research process. Tracing these steps is important; but arguably *not* as a means of verifying the validity or reliability of my findings, nor to allow others to 'replicate' them. Rather, they need to be told because of their influence on the 'story' about the views, experiences, and needs of the 58 staff and prisoners I interviewed. Recounting them is, in itself, an important part of the process of producing accountable, "unalienated and unalienating knowledge" (Stanley, 1990).

The positivistic concerns with validity and reliability are not of relevance to this research paradigm, yet research must be rigorous (see also Crowe, 2005). In the words of Denzin and Lincoln (1994, p. 114), this involves considering the:

> Historical situatedness of the inquiry, the extent to which the inquiry acts to erode ignorance and misapprehensions and the extent to which it provides a stimulus to action, that is to the transformation of the existing structure.

A feminist praxis suggests that, rather than engaging in futile attempts to avoid 'bias', researchers need to continually reflect on the *what* and *how* of their practice. In order to produce ethical and politically conscious knowledges, our own standpoints (Harding, 1991) and perspectives should be both accountable and visible, as should the context of our research (Willig, 1999b).

Although I aimed to never lose sight of the interview data, and to avoid "textual appropriation of the researched" (Opie, 1992, p. 53), my analysis is inevitably incomplete, imperfect and situated. The material I collected and (co)created is open to a myriad of meanings and interpretations, and will be continually (re)analysed by myself and others whenever it is read (Ciclitira, 1998). Therefore, the story I am about to tell is and "should always be open to criticism" (Holland & Ramazanoglu, 1994, p. 146).

Chapter 3. Professionals' Responses to Repetitive, Non-Suicidal Self-Harm

To contextualise the research reported in this thesis further, this chapter is the first of two reviewing current knowledge and discussions of staff's reactions to self-harm. As discussed in previous chapters, exploring the perspectives of those working with people who self-harm is an "essential" (Liebling, 1992) - but often overlooked - component in the study of self-injury. This is particularly the case in a prison setting, where staff have regular, potentially daily contact with prisoners who self-injure. This has been shown to be associated with a range of anxieties and negative emotions (see e.g. Arnold, 1995; Fish, 2000), which are not only detrimental to the welfare of staff, but may also have negative implications for the people in their care - and, potentially, for their self-harming behaviour (Arnold, 1995; Liebling & Chipcase, 2001).

Given the paucity of research on the impact of self-harm on prison staff (which is reviewed in Ch. 4), this chapter locates this topic within the broader literature on professionals' responses to self-injury. In the account which follows, the terms 'staff', 'workers' and 'professionals' will be used, interchangeably, to refer to people dealing with 'clients' (including 'patients', pupils and prisoners) who self-injure, in a broad range of professional and work settings (e.g. nurses, GPs, social workers, teachers, counsellors, mental health workers and psychiatrists).

Please note that, although the current research is specifically concerned with workers' responses to repetitive, non-suicidal self-harm, some of the studies reviewed use broader and less clearly defined terms. There is a great deal of variation in the definitions and terminology employed in the literature, and the range of behaviours explored, which is perhaps inevitable given the definitional problems inherent in the term 'self-harm', and the notion of suicidal intent (see Ch. 1.1). Nevertheless, studies dealing *exclusively* with the impact on staff of (seemingly) suicidal forms of self-harm and/or self-inflicted deaths are not included in the following review (but are briefly discussed in the following chapter, and considered more extensively elsewhere - see e.g. Borrill et al., 2004; HMCIP, 1999; Snow and McHugh, 2000). Arguably, the subject of staff working with people with self-injure needs to be examined separately from the matter of staff

dealing with suicides, since the issues that may be specific to working with self-harm could be eclipsed by the priority generally given to suicides.

3.1 Review of the Wider Literature on Staff's Responses to Repetitive, Non-Suicidal Self-Harm

Until recently, relatively few studies had specifically investigated professionals' responses to self-harm. Much of what was known about this subject was derived, indirectly, from the literature centred on "users" (McAllister, Creedy, Moyle, & Farrugia, 2002), i.e. studies focusing on the experiences of people who have used social and health care services following self-injury (e.g. Pembroke, 1991). The picture emerging from this body of research is a bleak one. People who self-harm are shown to be generally dissatisfied with emergency and psychiatric services (e.g. Arnold, 1994), and often experience judgmental comments and painful treatments, sometimes perceived by clients as a punishment for their self-harming (Hemmings, 1999).

> Cases have been reported where local anaesthetic has been withheld, even when there has been stitching, and frequently self-harmers have been given inappropriate dressings and treatments [...] They are often ignored or treated with contempt or little respect [...] and have been refused treatment on the basis that the wounds were self-inflicted and therefore 'not worth' treating. (Jeffery & Warm, 2002, p. 296)

Although not specifically concerned with the impact of self-harm on staff, the user literature has made at least two important contributions to this field of research. Firstly, it provided robust evidence to suggest that self-harm tends to evoke strong emotions and negative attitudes in staff from a variety of occupational and organisational groups. This finding has also received support from a smaller body of 'professional literature' (McAllister et al., 2002), seemingly designed to test workers' (limited) knowledge of self-harm and expose their negative attitudes towards clients who self-injure (e.g. Crawford, Geraghty, Street, & Simonoff, 2003).

Secondly, research focusing on clients' experiences of "services" (Batsleer, Chantler, & Burman, 2003) and "service providers" (Jeffery & Warm, 2002), has brought attention, in a very powerful way, to the detrimental impact of staff's negative attitudes on clients.

A response of rejection or hostility from staff can reinforce feelings of isolation, low self-worth, and loss of control (Fillmore & Dell, 2000; Pembroke, 1991). This can exacerbate clients' distress, precipitate further self-harming and increase the already high likelihood of their committing suicide (e.g. Clarke & Whittaker, 1998; Towl & Forbes, 2002).

However, the user literature provides little or no information as to why staff may respond to self-harm in such negative ways, how *they* may be affected by clients' self-injurious behaviours, and what, if anything, could be done to prevent these hostile reactions. Whilst very critical of workers, these studies provide a rather uncritical and simplistic view of staff, and staff-client dynamics.

According to McAllister (2001, p. 393), "the perception that patients who self-harm receive inadequate care" is a common, "standard story" of "the weak and vulnerable being dominated by the arrogant and insensitive professionals [...] it is a story about us and them, about good and evil, about right and wrong". This narrative embodies and (re)produces dominant and essentialist discourses of 'bad', uncaring staff, whilst moving one "to feel for those who have been wronged". It is underpinned by a dualistic anti-staff/pro-client discourse, and simultaneously implicated in its maintenance. However, this type of "binary thinking may help to make sense, provide order and structure, but it also risks oversimplifying complexity" (*Ibid.*).

Some useful alternatives to this 'standard' story come from the professional literature on staff's responses to self-harm. By exploring staff-client dynamics from the point of view of workers, and investigating *their* experiences, views and concerns, these studies have tried to understand, rather than merely 'expose', staff's negative attitudes to self-injury. Within this paradigm, a number of studies have examined the reactions of staff working with people who self-harm in Accident & Emergency departments (Anderson, Standen, & Noon, 2003; Hawton, Marsak, & Fagg, 1981; Hemmings, 1999; Johnstone, 1997), teaching hospitals (Crawford et al., 2003), and general hospital settings (Simpson, 1975, 1980). Similar studies have also been conducted within community mental health services (Arnold, 2005; Chantler et al., 2001; Huband & Tantam, 2000) and medium secure forensic psychiatric settings (Fish, 2000; Gough & Hawkins, 2000). More

recently, following evidence of the alarming extent of self-harm amongst young people (see NICE, 2004), researchers have also begun to investigate the experiences of teachers and other professionals who work in or with schools in supporting and responding to pupils who self-harm (Best, 2004, 2005).

Overall, these studies are consistent with the user literature in suggesting that people who self-harm are "not-popular" (Mackay & Barrowclough, 2005) amongst workers. Indeed, a recent study found that, together with the "aggressive client", the "vulnerable, impulsive [non-suicidal] self-harming client" was rated by staff in mental health services as *the* most difficult and distressing client group with whom to deal (Hayward, Tilley, Derbyshire, Kuipers, & Grey, 2005). By taking a worker's perspective, these studies have also been able to describe - with remarkable consistency - the range of feelings, cognitions and behavioural reactions commonly experienced by staff in these complex work situations. However, the exact reasons why dealing with this behaviour may raise particular anxieties and responses in workers are not well-established, and may indeed be multiple. The following section will review some of the main accounts put forward to explain staff's reactions to self-harm.

3.1.1 Cognitive Accounts

Pannell et al. (2003), amongst others (e.g. Jones, Miller, Williams, & Goldthorpe, 1997; Stanley & Standen, 2000), have explained staff's negative attitudes towards self-harm within a cognitive-emotional model of helping behaviour (e.g. Dagnan, Trower, & Smith, 1998). According to this model, non-suicidal self-injury tends to be perceived by staff as being a "controllable" (Weiner, 1986) "challenging" (Stanley & Standen, 2000) behaviour, and, to this extent, is judged to be the responsibility of the individual concerned. This, in turn, is thought to lead to feelings of anger and subsequent behavioural reactions, such as reduced willingness to help, neglecting, reprimanding or even retaliating behaviour (Pannell et al., 2003).

Others have speculated that the direct, self-inflicted nature of an act of self-harm can make this form of behaviour seem "bizarre" (McAllister et al., 2002), or even "incomprehensible" (Frost, 1995). This, in turn, may leave staff feeling confused, unsure and resentful towards clients, whom they may perceive as being neither "good" nor

"deserving" of their care (McAllister et al, 2002). In some cases, particularly when "relatively trivial in nature", self-harming may be interpreted as being "deceptive" and attention seeking (Bowers, 2002, p. 325). Staff may feel coerced, or even manipulated, to express concern and give care, and that sense of obligation can be experienced as a form of bullying or aggression from the client (Bowers, 2003a; Fish, 2000).

These reactions have been described as 'normal', to some extent, on the grounds that a) clients who self-harm may indeed be trying to manipulate staff, and b) there are "natural responses to self-injury (e.g. horror, anger, frustration) that are not easy to contain or ignore, and contaminate interactions with patients" (Bowers, 2002, p. 54). However, it may be suggested that these arguments need to be made with some caution, because they risk naturalising negative responses to self-harm. In so doing, they may be seen to condone, and almost romanticise, staff's hostile reactions, whilst overlooking the detrimental impact these can have on clients.

It has also been argued that, regardless of whether there may indeed be an instrumental element to some self-harming, there is a tendency amongst staff to over-attribute manipulative motivations. This has been described by Linhean (1993) as a "logical error", a cognitive distortion. As pointed out by Bowers (2003b, p. 327), "part of the problem in this area is that negative attitudes are, to a degree, self-sustaining". In order to "play it safe", staff may become cynical and mistrustful in relation to self-harm, which, in turn, may elicit an angry, and possibly "self-fulfilling", response from the client (*Ibid.*).

3.1.2 Psychodynamic Accounts

Whilst these accounts tend to focus on the perceptions, attributions and (lack of) knowledge of staff dealing with self-injury, others have explained professionals' responses to self-harm in terms of the feelings and emotions evoked by this behaviour. From a psychoanalytic perspective, negative reactions to self-harm, including the labelling – and dismissing – of the behaviour as 'manipulative' and 'attention seeking', have been conceptualised as a "defence mechanism", i.e. a coping strategy developed by workers to protect themselves "against the complex and ambivalent feelings engendered by the work" (Batsleer et al., 2003, p. 105).

Research has consistently shown that, particularly when dealing with people who repeatedly injure themselves, staff can feel helpless, betrayed and powerless (Arnold, 1995). Their inability to "make the behaviour stop" (Boyes, 1994; McCarthy, 2003), as well as difficulties in building relationships with people who self-harm (e.g. Huband & Tantam, 2002), and feelings of not being able to cope with their demands (McAllister et al., 2002; Ramon, 1980), may leave staff feeling angry, disillusioned and frustrated. In addition, clients may "project" their negative feelings and anxieties onto staff, "bringing up emotions in them that they find difficult to deal with" (Rayner, Allen, & Johnson, 2005, p. 14). This adds to the potential "trauma of the actual injury" (Fish, 2000), and the stress of witnessing and learning about horrific experiences which may leave them feeling shocked, upset and angry, or may remind them of their own sadness and distress, or even, their own self-harming behaviour.

The psychoanalytic literature suggests that, as a result, workers may develop complex counter-transference reactions, including guilt, rescue fantasies, transgression of professional boundaries, anxiety, rage and terror (for a more detailed discussion see Gabbard & Wilkinson, 2000; Rayner et al., 2005). By rejecting, 'Othering' (Peternelj-Taylor, 2004) or otherwise distancing themselves from the client, staff may be able to locate the source of difficulty with the client, as opposed to themselves and their own knowledge, skills and beliefs (Huband & Tantam, 2002), and at the same time, "drive a wedge between the self and the source of hurt, trying to 'outhurt the hurter'" (Batsleer, et al., 2003, p. 105). Their anxieties may in turn be projected onto the client and precipitate further acts of self-harm (Clarke & Whittaker, 1998).

The concept of 'splitting' has also been invoked to explain workers' responses to self-harm. As noted by Simpson (1980), amongst others (e.g. McAllister et al., 2002), staff's feelings following an incident of self-harm are not *all* negative, but can fluctuate between rage, guilt, sympathy and resentment. Such "contradictory" feelings are thought to produce a "split response" in staff (Batsleer et al., 2003), i.e. "the polarisation of good and bad feelings [...] keeping contradictory intrapsychic aspects apart" (Rayner et al., 2005, pp. 13-14). In the words of Batsleer et al. (2003, p. 105), "either caring/empathetic or punitive feelings can be split off in order to defend against the anxiety created by

encountering those feelings occurring at the same time and in response to the same person". The concept of splitting may therefore explain why staff seem to regard (some) clients who self-harm as "all bad" and "undeserving" (as opposed to "all-good" and "deserving") (Spandler, 1996). Recent discussions have pointed out that this kind of 'split assessment' may also take place in response to different diagnostic categories and types of self-harm, whereby certain episodes and client groups (e.g. the potentially life-threatening self-harm of a psychotic client) are seen as more deserving of attention and care than others (e.g. 'superficial' self-inflicted cuts, as part of a 'personality disorder') (see Batsleer et al., 2003).

Arguably, cognitive and psychoanalytic accounts are both useful in explaining, at the micro-level, why individuals dealing with people who self-harm may exhibit hostile and unhelpful responses. These approaches, albeit with their different emphases, highlight the thoughts, feelings and behavioural reactions experienced by staff in these complex work situations, and the ways in which they may come to "develop coping strategies that do not benefit clients" (Batsleer et al., 2003, p. 104), or, sometimes, themselves (e.g. Schaufeli & Peeters, 2000). However, the experiences and individual differences that may underlie more positive responses to self-harm are more rarely discussed in this literature (some exceptions are Huband & Tantam, 2000; Ireland & Quinn, 2007; Mackay & Barrowclough, 2005; McAllister et al., 2002). Indeed, by normalising negative reactions to self-injury, some of these accounts may be seen to imply that these are inevitable. Furthermore, by focusing so closely on the individual these explanations risk overlooking the ways in which wider organisational and occupational factors may influence workers' responses. In so doing, they shift the responsibility for negative attitudes (and poor performance) away from the organisation and onto the individual employee.

3.1.3 'Work Stress' and Staff's Responses to Repetitive, Non-Suicidal Self-Harm

Staff's attitudes to clients "cannot solely be conceived as the isolated production of an individual member of staff [...] that is not the whole story" (Bowers, 2002, p. 93). For this reason, it may be suggested that the work stress literature can provide a more useful theoretical framework within which to conceptualise this topic. By concentrating on the

dynamic interactions between individuals and their environments, a transactional model of work stress (Lazarus & Folkman, 1984) can maintain a focus on the cognitive processes and emotional reactions of staff, whilst allowing a fuller understanding of the *context* of professionals' responses to self-harm, and hence the ways in which broader cultural and structural issues may affect workers' views, experiences and attitudes.

A basic, and perhaps commonsensical, premise of the work stress literature is that the "context" and/or the "content" of work (Cooper & Marshall, 1976) can affect individuals' reactions, and the likelihood of their experiencing stress. In particular, according to Lazarus and Folkman's (1984) transactional model of emotion and stress, "stress" is "a particular relationship between the person and the environment [in this case, the work environment] that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (p.19). Within this framework, the strain of staff working with clients who self-injure has often been discussed with reference to workers' roles and responsibilities in this area of work. For instance, Hayward et al. (2005) have argued that "the self-harming client is engaging in socially unacceptable behaviours, behaviours which staff may feel responsible for, but which they are in fact relatively powerless to prevent" (p. 299). Such feelings of helplessness, which Deiter and Pearlman (1998) have described as potentially "traumatising", can also challenge their views of autonomy, competency and role (Rayner et al., 2005, p. 13). This, in turn, may set in motion some of the coping and defence mechanisms described in earlier sections. Furthermore, and particularly when staff have a duty of care towards clients, "a self-injuring patient frequently raises anxiety in professional staff arising from fear from [his or] her safety, from concern about repercussions if [he or] she makes 'one cut too many'" (Fieldman, 1998, p. 258). This can create a climate of blame and fear, and, in the long term, is thought to lead to "professional burnout", a "syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment that can occur among individuals who do 'people work' of some kind" (Maslach & Jackson, 1986, p. 2; see also Cherniss, 1980; Maslach & Schaufeli, 1993).

The gradual process of "burning out" following "chronic and serious job stress" is described, very clearly, by Schaufeli and Peeters (2000, pp. 21-22):

> In human services professions considerable stress is caused by the emotionally demanding relationships with recipients (e.g. pupils, patients, clients, or prisoners) that eventually may result in the depletion of one's emotional resources. Next, a set of negative attitudes and behaviours is developed, such as a tendency to treat recipients in a detached and mechanical manner [...] however, this is an inadequate coping strategy that increases stress rather than reduces it, because it diminishes the relationship with recipients and aggravates interpersonal problems. As a result, the professional is less effective in achieving his or her goals so that personal accomplishment diminishes and feelings of incompetence and self-doubt may develop.

One of the strengths of this concept is that, unlike many other accounts of staff's 'defensive coping mechanisms', it considers the potential implications of hostile attitudes and behaviours on staff themselves, as well as clients. There is a vast, and well-established body of research suggesting that work stress and burnout can have psychological, physiological and social effects on workers (ranging from job dissatisfaction to depression and coronary heart disease), as well as repercussions for the organisations for which they work (e.g. in terms of poor performance, high turnover and absenteeism) (for reviews of the effects of burnout and work stress see, respectively, Garland, 2004; and Rick, Thomson, Briner, O'Regan, & Daniels, 2002).

Furthermore, by locating these reactions and effects within their wider context, this theoretical framework may help to shift attention – and blame – away from individual staff, and onto the organisational and occupational systems, structures and processes that may cause, "buffer" (Heaney & van Ryan, 1990) or prevent work-related stress, and associated strains (including burnout, negative reactions, absenteeism and job dissatisfaction). In summarising previous research in this area, Cox (1993, p. 35) commented:

> Work situations are experienced as stressful when they are perceived as involving important work demands which are not well matched to the knowledge and skills (competencies) of workers or their needs, especially

when those workers have little control over work and receive little support at work.

This, in turn, implies that, whilst dealing with people who self-harm is not *inevitably* stressful, professionals are more likely to experience stress, and develop negative reactions to self-harm, when unqualified, untrained and inadequately supported by colleagues and managers. Adding further strength to this claim is "evidence of decreased strain" amongst staff trained "in assessing and responding to people who deliberately self-harm" (Holdsworth, Belshaw, & Murray, 2001, pp. 445, 449) (see also Crawford, Turnbull, & Wessely, 1998; McAllister, 2003b; NICE, 2004), and who feel "valued" (Liebling, Tait, et al., 2005) and "supported" (Crawley, 2004). Moreover, and despite there being little empirical evidence to substantiate these claims (for a review see Stevenson & Jackson, 2000), there is growing consensus in the literature that regular clinical supervision is useful - and perhaps "essential" (Chantler et al., 2001, p. 87) - to avoid staff burnout and create a supportive environment for those who self-harm (Clark, 2002; Liebling & Chipcase, 2001; NICE, 2004), especially if used in conjunction with "in-service training, group discussions [...] staff selection, staffing procedures and an awareness of signs of 'burnout'" (Burrow, 1992, p. 147).

Setting the context of professionals' responses to self-harm also serves as a useful reminder that dealing with self-injury is often only one of many potential sources of stress, burnout and trauma in the workplace. Unhelpful reactions to clients who self-injure may not necessarily - or not exclusively - be related to negative attitudes towards the behaviour, or to the strong feelings it may evoke. Indeed, these responses may be the indirect consequence of unrelated aspects of the work environment (e.g. having to deal with violent clients, or feeling undervalued by managers), or even a "spill-over" from their home life (Burke, 1986). Arguably, these also need to be addressed if staff are to respond to self-harm in more positive ways.

Evidence that these interventions tend to be rare in practice (see e.g. Giga, Noblet, Faragher, & Cooper, 2003; Jordan et al., 2003; Rick, Young, & Guppy, 1998), suggests that:

> The problem, or wrongdoer, is more likely to be found in the system than in individual nurses [or other professionals]. While the standard story may suggest some nurses [or staff] to be misguided, or wrong for the job, a novel reading reveals that [it is] the health care system which makes unrealistic demands [on staff]. (McAllister, 2001, p. 394)

3.1.4 Limitations of the Work Stress Literature

As a response to *chronic* stress, the concept of staff burnout may be particularly relevant when discussing the potential effects of dealing with repetitive self-harm. Nevertheless, there is evidence that dealing with self-harm may also be traumatising for staff. Unfortunately, very little has been written on the potential effects of more routine traumatic stressors, i.e. ongoing, yet lower level incidents that can give rise to symptoms of trauma. Much of the literature on trauma in the workplace is biased towards one-off "headline friendly" events (Rick et al., 2002), and hence may add little to our understanding of the effects on staff of dealing with repetitive, non-suicidal self-harm.

Another limitation of the work stress literature is that, whilst emphasising how structural and material conditions may influence staff, it appears to pay little attention to the possible impact of the institutional culture(s) on workers' reactions, representations, and practices (and vice-versa). Most of the studies in this area seem to have focused on the more tangible - and more easily quantifiable - aspects of the work environment, ranging from noise levels (e.g. Jones, 1983), to organisational size and structure (e.g. Kasl, 1992), workload and work schedules (for a review see Cox, 1993). This could be because much of the research conducted in this field belongs to a positivist, experimental paradigm, which in its quest to produce 'hard' science and testable hypotheses, tends to priviledge parsimony over complexity, so-called objectivity over subjectivity (which may seem paradoxical considering how many of these studies rely – often exclusively – on self-report measures). However, it may be suggested that professionals' responses to self-harm are complex, dynamic and multidimensional

(McAllister et al., 2002). Furthermore, it may be argued that the reactions of staff to clients who self-injure are socially and culturally constructed; they are shaped, legitimised and sustained by the cultural representations, narratives and practices proliferating within their disciplines and organisations, as well as by wider contemporary discourses around self-harm. This implies that "the comments [and, indeed, the apparent attitudes and reactions] of individuals should not be taken at face value, rather, they need to be located in wider structures of discourse and power so that their implications and ramifications can be fully understood" (Crossley, 2000, p. 36; see also Ch. 2.11).

3.1.5 Critical (Realist) Social Constructionist Approaches

Whilst the work stress literature can arguably provide a valuable *theoretical* framework for this area, a critical social constructionist paradigm (see Burr, 1995; Danziger, 1997) may be a more useful analytic approach to the study of professionals' responses to self-harm. By exploring the ways in which discourses serve to construct meaning, and by 'deconstructing' staff views and reactions, it may be possible to identify and challenge the "normative regularities of what passes for a culturally reasonable explanation" (Redley, 2003, p. 350), i.e. the collective "schemes" used by professionals to give meaning and value to their experiences (McAllister, 2001). This has been taken to involve critically questioning everyday, natural(ized) and 'normal' practices, whilst attending to the resistances, contradictions, and omissions in workers' talk. In so doing, a social constructionist approach can bring attention to hegemonic and hidden contradictions of practice discourses (Freshwater, 2002), hence "trouble some taken-for-granted assumptions", whilst "opening up previously hidden aspects to the story" (McAllister, 2001, p. 396).

Please note that the term "critical social constructionism" is used to differentiate this paradigm from the relativist, "lighter versions" (Danziger, 1997) of social constructionism, that do not subscribe to a critical realist ontology (see Ch. 2.11). Of interest here is the more political strand of social constructionism, which locates discourse in relations of power. As explained by Cromby and Nightingale (1999, p. 6),

"while social constructions are relative, they are not arbitrary, but emerge through social processes that are already shaped by influences such as power relationships and material resources". Although these ideas are more conventionally referred to as "dark social constructionism", this terminology has come under scrutiny, for carrying "inflections of Enlightment discourse, which itself is inscribed by histories of racism and colonialism that are always evoked by discourses of vision and colour" (Burman, 1999, p. 172).

This strand of social constructionism has already been applied – successfully – to the study of self-harm, and of workers' reactions to clients who self-injure. For instance, in relation to nurses' responses to self-harm, Clarke and Whittaker (1998) have shown that locating self-injury within a cultural framework, and thus "emphasising self-mutilation as a culturally defined phenomenon" (p. 130), can enlarge the debate beyond the confines of medical/nursing perspectives. This, in turn, may assist in "de-psychiatricising" self-mutilation (*Ibid.*) and re-defining the behaviour seperately from suicide or suicidal intent, "delusions, hallucinations or serious mental illness" (Favazza & Rosenthal, 1990). The authors suggest that, by moving away from "clinical philosophising" and medical approaches in this area, nurses may start to look beyond "presenting symptoms", and adopt a more permissive approach to self-injury, which is seemingly more effective from the client's perspective (see e.g. Pembroke, 1991). In other words, this process of deconstructing medical accounts and labels (which arguably contribute little to our understading of self-harm) can help nurses review, and critically reflect on their negative responses to this behaviour, and begin to see the issue "from the self-mutilator's perspective" (Clarke & Whittaker, 1998, p. 136). As argued by McAllister (2001), this generates new, and transformatory, possibilities; "rather than a signifier of failure, self-harm may point to solutions" (p. 396).

Previous research in this area indicates, that, as well as deconstructing wider discourses around self-harm, it useful to explore, at the micro-level, the ways in which meanings surrounding this behaviour are talked about by staff. As pointed out by Batsleer et al.

(2003), this can occlude wider systemic issues[9], and may serve to construct the client as 'Other', with clear implications for staff-client dynamics. This exploration of 'Othering' is thought to be especially important in forensic settings, where patients and prisoners are often depersonalised through the use of language (e.g. Holmes and Federman, 2003). In this context, "not only do 'Othering labels' elicit strong emotions, stigmatise and sterotype, but they all construct the person as something other than a person, in many cases as a 'monster'" (Peternelj-Taylor, 2004, p. 136), a problem or an illness.

This is also said to include terms that on the surface appear innocuous (*Ibid.*). For example, Groves' (2004) analysis of staff's responses to self-mutilation in Australian prisons, and analysis of the labels used in this context to describe prisoners who self-harm, suggest that the "manipulation" theme so often endorsed by staff, and even the more "sympathetic" view of self-harm as a "genuine" "cry for help", actually serve to construct the person as inseparable from the act of self-harm. This, in turn, locates self-injury within the individual, rather than the institution. In the author's own words, "self-mutilation may indicate that the person is either antisocial or in distress, but in either case, it is essentially a product of the prisoner [...] a reality that preceedes, or is, in some sense, outside the regulatory regime of the prison" (p. 59). As a result, the only involvement and responsibility of the prison in relation to self-harm becomes that of "managing" the problem, ultimately by increasing knowledge and surveillance of prisoners at "risk". However, drawing on the Foucauldian notion of "disciplinary power" (Foucault, 1977), Groves suggests that this is likely to perpetuate the problem. Indeed, the "regulation" of self-harm in prisons is said to be also what produces it in the first place, and continually reproduces it (see also Butler, 1996). "These acts [of self-harm] have no meaning at all before a response is made; it is through this regulation that the meaning of self-mutilation is constituted" (Groves, 2004, p. 59).

Whilst not everyone may agree with Groves' (2004) radical conclusions, it may be argued that this type of analysis can not only enrich academic understanding of this

[9] For instance, by pointing to the ways in which male workers in their study explained clients' self-harm in terms of "difficult or unhappy relationships" (rather than consider the possible links with gendered issues such as sexual abuse, domestic violence and rape), the authors provide a powerful example of discourse that can occlude wider systemic issues, or, in their own words, "sanitise, minimise and make invisible the depth of distress and abuse in some women's lives" (p. 108).

topic, but may also have implications for developing practice, most notably by suggesting how workers can be "constructively challenged" through supervision (Batsleer et al., 2003, p. 113). Unfortunately, this type of approach is still relatively rare, and more or less "subjugated" (Foucault, 2003) in psychology. In relation to self-harm, much of this deconstructive work has been carried out within feminist psychological approaches, in the context of a "hegemonic struggle" with "official" (male) psychiatry, i.e. a political battle over what type of knowledge should come to constitute common sense with regards to self-harm (for a more detailed discussion see Cresswell, 2005). The legitimate political quest to produce a hegemonic 'truth' of self-harm as a gendered issue has resulted in a wealth of research deconstructing dominant discourses around female self-harm. Unfortunately, this has meant that the cultural practices and discourses surrounding *male* self-harm - and professionals' responses to male clients who self-harm - have remained largely unexplored (see also Ch 1.4.1).

Whilst these considerations suggest that a critical social constructionist paradigm can offer a promising avenue for the current research, it is important to note some of the limitations of this approach. Firstly, by deliberately avoiding questions of agency, social constructionist approaches may be accused of reductionism, and can risk 'losing the subject'. Even when acknowledging the 'reality' of individual experience and subjectivity, there is a danger that "language and context are emphasised to such an extent that the self is engulfed, if not annihilated" (Crossley, 2000, p. 32). However, professionals' responses to self-harm are produced and sustained "through the discourses of a number of subcultures of which individuals are members *as well as* through personal experience" (emphasis added; Lupton & Tulloch, 1999, p. 516).

Secondly, although critical social constructionists locate their analysis within the social, such work often seems to remain at a theoretical and rather abstract level (Abel & Stokoe, 2001). As argued by Cowburn (2004), it is often "written in highly abstract and complex language, which whilst it may have a currency within the esoteric world of the social science/arts academy it is questionable how widely influential it can be beyond the academy" (p. 500). Particularly given the current hegemony of quantitative, "evidence-based" research (especially in the form of randomised controlled trials), social

constructionist approaches may have limited influence over policy and practice, which is crucial in the context of the current research.

3.2 Summary and Conclusions

Contemporary studies on professionals' responses to self-harm tend to fall in three (by no means exclusive) categories:

1. The "user" literature 'exposing' staff negative attitudes to self-harm, and exploring their implications, from clients' perspectives.
2. The professional literature, which is generally more sympathetic to staff, and aims to explain - and, to a certain extent, *justify* - workers' negative attitudes by examining the impact of self-harm on staff (in relation to cognitive, psychodynamic and/or occupational/organisational factors).
3. A smaller body of critical social constructionist research exploring the ways in which cultural discourses and narratives shape and sustain professionals' responses to self-harm (particularly in relation to female self-harm).

Each of these approaches has made some contribution to this field of study. By focusing on the dynamic interactions of individual members of staff and their environments, the work stress literature can arguably offer the most comprehensive theoretical framework. A transactional model of work stress can account for cognitive and psychodynamic individual processes, as well as for the influence of wider organisational and occupational factors. Within this framework, the concept of burnout may be a particularly useful one to understand the impact on staff of dealing with repetitive, non-suicidal self-harm. However, the social constructionist literature may be seen to offer the most valuable analytic paradigm. A critical deconstructive approach may capture the institutional and organisational cultural contexts of professionals' responses to self-harm, which are often neglected by more mainstream work stress research. A synthesis of the two can provide a comprehensive framework for analysing staff's reactions to self-injurious behaviours, as well as to suggest how these may be addressed in practice (see Ch. 8).

Overall, previous research in this area suggests that:

1. Many staff "have little sympathy or understanding of this area and may well react punitively" (Clarke & Whittaker, 1998, p. 136).
2. Dealing with people who self-harm raises a number of complex issues for professionals. This challenging area of work can have implications for the welfare of both staff and clients, as well as for the wider organisation.
3. Staff's responses to clients who self-injure are likely to be influenced by their (often negative) individual experiences of working in this area, the content and context of such work, and by broader cultural discourses around self-harm. Indeed these three factors are likely to be interconnected.
4. Negative responses to self-harm – albeit seemingly predominant – are not inevitable. Aside from possible (but under-researched) individual differences, there are a range of interventions, systems and processes that can by initiated by an organisation to prevent or reduce the impact of self-harm on staff, and associated effects (see also Ch. 8).

On this basis, it seems plausible to conclude that, whilst the wider literature on professionals' responses to self-harm can offer a framework for exploring the reactions of staff dealing with self-injury in prisons, it is useful to understand these *in context*. Indeed, even though there is evidence that the attitudes, feelings and reactions described in this chapter are common amongst the majority of staff working with people who self-harm (at all levels and in all occupational settings), the pressures and difficulties experienced by prison staff working in this area appear to be in many ways unique, and perhaps particularly acute. Therefore, the following chapter will review the literature on the impact of self-harm on workers, within the specific organisational and cultural contexts of prisons.

Chapter 4. Prison Staff's Responses to Repetitive, Non-Suicidal Self-Harm

In this chapter, the wider debates, theories and frameworks delineated in Chapter 3 are applied to the specific context of prisons. Consistent with research carried out in other organisational settings, the existing prison-based literature suggests that dealing with the effects of suicide and self-harm in custody is one of the strongest predictors of psychological distress in prison staff in England and Wales (Liebling, 2003; as cited in Safer Custody Group, 2003). Similar findings have been reported elsewhere. In Canada, for example, Fillmore and Dell (2000) found that 75% of staff reported increasing feelings of tension and stress when women prisoners self-harmed (see also Chowanec et al., 1991; Lohner & Konrad, 2006). Furthermore, there is evidence that prisoners who self-harm place "particularly draining" demands on staff (Paton, Harrison, & Jenkins, 2000), potentially leading to feelings of anger, disillusionment, frustration, and futility (HMCIP, 1999). For instance, Liebling, Tait, et al. (2005) reported that staff were "challenged and under-resourced in relation to self-harm, especially repetitive self-harm" (p. 175). This may be related to the finding that prisoners who repeatedly self-harm and/or do so with no apparent suicidal intent are particularly likely to experience stigma and hostility from staff (e.g. Snow, 1997). Compared with seemingly suicidal forms of self-harm, this type of behaviour is more likely to be labelled by staff as "attention seeking" and "manipulative", and to be perceived as a deliberate threat to their authority (Liebling, Tait, et al., 2005).

Recently, there have been some suggestions in the literature that these attitudes, whilst not *justified* (Crawley, 2004), may be somewhat *understandable* (Liebling, 1998). However, the question of what underlies or explains staff's (negative) responses to self-injury has yet to be explored in any depth, particularly with regards to non-suicidal self-harm. Drawing on the work stress literature, this chapter explores the ways in which the "context" and "content" (Cooper & Marshall, 1976) of prison work may influence how staff are affected by, and deal with prisoner self-harm. This is followed by a discussion of the occupational and organisational issues that may be specific to officers, healthcare and specialist prison staff, and their reactions to prisoner self-harm. In light of critical social constructionist approaches, particular attention is paid to the potential impact of wider cultural practices and discourses on staff's responses to self-harm. The chapter

concludes with a brief summary of key themes in the literature, and a consideration of the main aims and objectives of the present study.

4.1 Prison Staff Working with Repetitive, Non-Suicidal Self-Harm: A special case?

Whilst there is evidence that the attitudes, feelings and reactions described in Chapter 3 are common amongst the majority of staff working with people who self-harm (at all levels and in all occupational settings), it seems reasonable to argue that the pressures and difficulties experienced by prison staff working in this area are in many ways unique, and perhaps particularly acute. The organisational and cultural contexts of prisons are such that staff working in this environment may be regarded as a special case.

It has been widely suggested that prison work is inherently stressful, regardless of one's role, grade or discipline (Armstrong & Griffin, 2004). Prisons have been described as the most stressful work environment in the UK, as well as the one with the highest sickness and turnover levels in the public sector (House of Commons, 1999; Lyon, 2003; Piper, 2003; for an international overview of job stress and burnout among prison officers see Schaufeli & Peeters, 2000). In recent times, staff retention figures have reached the lowest levels in the history of the service (Piper, 2003). This is probably not surprising given the current - and seemingly intractable - problems of under-staffing and overcrowding (for a more detailed discussion of the crises afflicting the Prison Service see Cavadino & Dignan, 2002; Liebling & Price, 2001), the growing number of "vulnerable" people in prisons (see e.g. Joint Committee on Human Rights, 2004), and the record numbers of suicides and self-harm in custody. The many changes and uncertainties, and threats of redundancies, that accompanied the introduction of NOMS, suggest that prison staff are currently working in a particularly difficult environment.

In this already stressful context, dealing with people who self-injure may be seen as particularly demanding for prison staff due to the increasing political and media interest in prison suicides and self-harm, and the finding of significant failures in compliance with suicide and self-harm prevention strategies (HM Prison Service, 2001). At a time when the minimisation of suicide and self-harm in custody is a repeatedly stated Prison

Service priority (see e.g. Safer Custody Group, 2001), prison staff also have to deal with issues of responsibility and accountability as never before. Moreover, in the context of prisons' managerialist "performance culture" (Carlen, 2002; Coyle, 2002; Scheerer, 2001), there is reason to believe that staff may feel particularly anxious when dealing with prisoners who self-harm - more so than most other professional groups working in this area. As contended by the Howard League (2003, p. 12), when trying to deal with self-harm prison staff operate in an environment:

> In which the success of their work is measured by a reduction in the number of incidents of self-injury. This means that even where staff are doing extremely good work with prisoners, the value of their work in the face of continued self-injury is not recognised, and staff are liable to take the emotional blame for continued self-injury.

These feelings are likely to be exacerbated by the lack of support available, in practice, for staff dealing with self-harm in prisons (e.g. Home Office, 2007), particularly with regards to repetitive self-harm (Marzano & Adler, 2007). For instance, there is formal post-incident support for staff following a self-inflicted death or a "serious" incident of self-harm (see HM Prison Service, 1998, 2004c), but no formalised procedures exist to support staff dealing with more pervasive, yet lower level self-harm. In addition, and despite the recent development of a training package specifically on self-injury (as opposed to suicide), there is evidence that most staff receive very limited - and even "inadequate" (UKCC, 1999, p. 10) - training on this topic, as part of the "standard [and *non* mandatory] suicide prevention training" (Liebling, Tait, et al., 2005, p. 194). The implementation of clinical supervision in prisons has also been described as "patchy" and lacking in "a systematic strategy" (Freshwater, 2005, p. 56), and remains almost exclusively available to healthcare staff. This is despite a number of guidelines suggesting that "*all* staff undertaking this work should have regular clinical supervision in which the emotional impact upon staff members can be discussed and understood" (emphasis added; NICE, 2004, para. 1.1.1.2).

4.2 The Impact on Officers of Repetitive, Non-Suicidal Prisoner Self-Harm

Of all staff groups working in prisons, officers are often portrayed - and, to some extent, stereotyped - as having the most negative attitudes towards prisoners who self-harm.

Indeed, their reactions have been described as being so negative as to suggest the existence of a "culture of staff carelessness" (Crawley, 2004, pp. 157-8; see also Liebling, Tait, et al., 2005). As explained by Crawley (2004, p. 158):

> There have been numerous accounts, in the literature and reports on prisons, of the tendency of some officers to behave in a blasé manner towards the prisoners in their care – i.e. ignoring or jamming cell bells [...] claiming that potentially suicidal prisoners are just 'trying it on', or 'just trying to get attention'.

Whilst this may be due to officers often being the *only* staff group consulted in relation to prisoner self-harm (when any staff are considered at all), it is possible that officers may indeed hold particularly negative attitudes towards self-injury. In turn, this may be due to "guard work being inherently more stressful than that of other prison staff" (Blau, Light, & Chamlin, 1986, p. 131). Virtually all of the risk factors identified in the work stress literature apply, more or less, to prison officers' jobs (Schaufeli & Peeters, 2000). This seems to be especially true of officers working in local prisons (like the one where the current research was conducted). As summarised by Liebling, Tait, et al. (2005), "they occupy a high demand, low control role[10]. Their work can be monotonous and frustrating, and it is generally low visibility work [...] It could be described as inherently frustrating and stressful" (p. 150; see also Cooper & Robertson, 2001).

In addition, it has been widely suggested that dealing with people who self-injure may be especially demanding for prison officers, because it brings into sharp focus their often competing roles of custody and care (Home Office, 1991; Towl & Forbes, 2002). Officers are required to "provide appropriate care and support for prisoners at risk of self-harm" (HM Prison Service, 2004b, p. 1), despite many of them having been "inducted into security routines as first priority" (Dolan, 1999, p. 12). Although recent evidence suggests that "the two faces of the correctional role" may be more compatible than previously speculated (Dvoskin & Spiers, 2004; Liebling & Price, 2001), there is little doubt that having to "balance authority with a large amount of understanding and

[10] Karasek's (1979) demand-control model predicts that the interaction of high job demand (in relation to the pace and volume of work, and the existence of conflicting demands) and low levels of job control (intended as "decision latitude" or "discretion") leads to high levels of physical and psychological strain (for a good discussion of this model see Jones & Bright, 2001).

compassion" (HM Prison Service, 2004b, p. 1), is a "complex challenge" (*Ibid.*), which may leave officers feeling unsure about their roles. Indeed, several studies have identified such "role conflict" and "ambiguity" (Triplett, Mullings, & Scarborough, 1996) as a major source of stress in prison work, and one of the strongest predictors of psychological strain and low job satisfaction (Cox, 1993; Mackay, Cousins, Kelly, Lee, & McCaig, 2004).

A further issue affecting officers working with prisoners who self-injure is their increased responsibility in the care and management of such prisoners. Following growing recognition of the crucial role of staff - and staff-prisoner relationships - in the prevention and management of suicide and self-harm, officers have come to be seen as the "backbone of suicide [and self-harm] prevention" (Rowan, 1994, p. 167; see also HMCIP, 1999). Prior to the 1990's, when suicides and self-harm in custody were primarily seen as a medical (or, more specifically, a psychiatric) problem, the role of officers on the wings was "limited" to identifying prisoners "at risk" and referring them to medical officers, who would "*necessarily*, take the lead in suicide prevention" (emphasis added; McHugh & Snow, 2002, p. 6). However, over the past 15 years, increasing awareness of the psycho-social and environmental dimensions to suicide and self-harm in prisons (HMCIP, 1990) has led to a fundamental re-examination of existing practices. This, in turn, has resulted in the adoption of a more holistic approach, where suicide and self-harm are seen to be "everyone's concern" (HMCIP, 1999). As argued by McHugh and Snow (2002, p. 15) "the most significant change in direction is the emphasis the revised strategy gives to *all staff* as having a responsibility in the identification of suicide risk and in provision of support" (emphasis added).

Whilst this new strategy has been widely welcomed, the main downside of adopting such a broad approach has been the growing number of non-specialist staff being asked to work with people with highly complex needs (Howard League, 2003). As a result, it appears that, "staff of all grades and disciplines often feel that they are 'unqualified', 'untrained' or 'unskilled' when conducting this kind of work" (Towl & Forbes, 2002, pp. 99-100). The recent influx in prisons of specialist 'outsiders', who are also involved in the care and management of self-harm in custody, may have lead to further "de-skilling" (Hay & Sparks, 1991), leaving officers to feel even less satisfied with their job

and undervalued by managers. As observed by Liebling, Tait, et al. (2005), some officers respond to these difficulties by avoiding work, "laying low" and "focusing on the more familiar procedural and disciplinary parts of their jobs" (p. 156).

These additional responsibilities and expectations on prison officers also need to be understood in relation to their already difficult relationships with both prisoners and management. In the context of the complex power dynamics – and power struggle[11] – between officers and prisoners, prisoner self-harming can become, and/or be perceived by officers as a form of resistance and rebellion, and hence a threat to their (unstable) positions of power. Officers may also be influenced by the conceptualisation of prisoners as "inherently dangerous" (Liebling, Tait, et al., 2005), yet "childlike" (Crawley, 2004), and the "universal, subcultural obsession of prison staff, that frequently they are being manipulated by prisoners" (Harding, 1994, p. 210). Indeed, since the Learmont Inquiry (1995), officers have been taught not to trust prisoners and to be more aware of "conditioning" (Crawley, 2004). Somewhat paradoxically, this is largely designed to maintain the security and safety of all concerned.

Officers' interactions with, and responses to prisoners who self-harm are also likely to be affected by the long-standing problem of staff discontent with management (see e.g. Fitzgerald & Sim, 1982; Hay & Sparks, 1991; Thomas, 1972). The perception, common amongst officers, that the authorities are more interested in the welfare and the rights of prisoners, than in those of staff, may heighten feelings of resentment towards prisoners. As explained by Crawley (2004, p. 158), "officers, who *as a group* feel unvalued and uncared for, and who often have more prisoners than cells, are likely to deny and minimise prisoners' problems and to express frustration and other negative attitudes towards prisoners requesting attention". As discussed in Chapter 3, "unsupported staff may be more likely to leave prisoners unsupported" *(Ibid.)*.

11 As explained by Crawley (2004), prison officers "are not in a particularly powerful position; on the contrary, they encounter a series of pressures towards compromise and accommodation" (emphasis added, p. 23; see also Sykes, 1958; Liebling and Price, 2001). Indeed, this is consistent with Foucauldian theorisations of power and power relations as being productive, rather than uniformly repressive and prohibitive. As Henriques et al. (1998) argue, "power is not one sided or monolithic, even when we can and do speak of dominance, subjugation or oppression. Power is always exercised in relation to resistance" (see also Lazard & Marzano, 2005).

4.3 The Impact on Healthcare Staff of Repetitive, Non-Suicidal Prisoner Self-Harm

Some of the pressures and difficulties described above are not dissimilar, or necessarily more acute than those experienced by healthcare staff working with prisoners who repeatedly self-harm, with no apparent suicidal intent. These, however, have received considerably less attention in the literature. Although medical and nursing staff have occasionally been involved in studies exploring suicides and self-harm in custody (Borrill et al., 2004), the issues and needs that may be specific to this group have yet to be considered in any depth. Research on stress and burnout in correctional treatment staff (Armstrong & Griffin, 2004; Flanagan, 2006; Flanagan & Flanagan, 2001) and the wider literature on nursing and medicine in secure environments (Doyle, 2001, 2003; Maeve & Vaughn, 2001; Weiskopf, 2005) have also neglected this area, despite self-harm being officially recognised as one of the most common health problems in UK prisons (Royal College of Nursing, 2001), as well as "one of the most difficult dilemmas for healthcare staff, often causing anxiety, frustration or anger" (Paton & Jenkins, 2002, p. 211).

Despite the lack of research on the views and experiences of doctors and nurses dealing with prisoners who repeatedly self-harm, it is possible to offer some suggestions regarding the likely impact of this area of work on medical staff, based on a) the findings of research on nurses' and doctors' responses to self-harm *outside* prison, and b) the broader literature on prison healthcare. The following section focuses particularly on the latter body of evidence. Outside prisons, nurses, and to a lesser extent, doctors, have been by far the most researched professional groups in relation to self-harm. Indeed, most of the studies reviewed in Chapter 3 have been exclusively or predominantly conducted with nurses, psychiatrists and/or physicians.

4.3.1 Nursing and Medicine in Prisons

The growing literature on prison healthcare suggests that working with self-harm within the context of prisons may bring some additional and unique challenges for staff. The carceral environment has been widely held to have very specific - and largely deleterious - effects on the practices and discourses of nursing and medicine in general, most notably with regards to staff's ability to 'care' for prisoner/patients (see e.g. Maeve, 1997; Maeve & Vaughn, 2001; Willmott, 1997).

Prison nursing and medicine have been described as unique, varied, complex and challenging (see e.g. Norman, 1999; Peternelj-Taylor, 2004). Commentators have highlighted the difficulties of working with a population with diverse, widespread and often acute clinical needs (Doyle, 2001; Watson, Stimpson, & Hostick, 2004), whilst having to find a way to relate to patients who are alleged to have committed crimes against the society of which staff themselves are a part, and which frequently are perceived by them as "aggressive and manipulative, dangerous, litigious, threatening, and possessing unclear motives for seeking healthcare" (Shields & de Moya, 1997, p. 43; see also Flanagan & Flanagan, 2001). This often takes place against a backdrop of poor resources and leadership (Whitehead, 2006) and, at the time of writing, of major organisational restructuring in the development of a partnership model between prison healthcare and the NHS (HM Prison Service/National Health Service Executive, 1999; see also Walsh, 2005; HMCIP, 1996). All of these factors are likely to be related to the recent vociferous critiques of individual healthcare systems and the wider prison health promotion culture (Dabney & Vaughn, 2000; Polczyk-Przybyla & Gournay, 1999; Sim, 2002; Smith, 2000). Critics have not only questioned the effectiveness of prison healthcare in managing and preventing prisoner suicide and self-harm (e.g. BMA, 2004) but, in some cases, have gone as far as to suggest that its current ethos, structure and conditions are deeply implicated in the production of these behaviours (see especially Smith, 2000).

Further compounding the difficulties of prison healthcare staff are the historical insularity of forensic nursing and medicine (Doyle, 2001), and the lack of recognition or, at times, professional stigma accorded to them, both within the prison system (where relations with governors and officers have long been described as fraught and uneven (BMA, 2001)) and by colleagues working outside the prison walls (Doyle, 2001; Watson et al., 2004). Feelings of powerlessness have also been frequently reported amongst correctional doctors and nurses, and are perhaps unsurprising if one considers that "prisons are not, primarily, concerned with the health of the prison population" (Watson et al., 2004, p. 120). As commented by the UKCC (United Kingdom Central Council for Nursing, Midwifery and Health Visiting) (1999), "priorities can be skewed towards security concerns and risk management rather than individual health needs, not only

within the wider prison system, but also, perhaps paradoxically, amongst healthcare staff themselves, who are said to fulfil a "dual caring and security role" (Walsh, 2005, p. 67). Such "double agentry" (Peternelj-Taylor, 2004, p. 13) is thought to have serious practical, ethical and philosophical implications for medical staff working in prisons, and is widely considered to be one of the main sources of stress and burnout amongst forensic doctors and nurses (Edwards et al., 2003; Flanagan & Flanagan, 2001; Happell, Martin, & Pinikahana, 2003).

There is extensive debate in the prison healthcare literature over "the perennial issue of care versus control" (Sim, 2002, p. 315) which is reminiscent – though seemingly oblivious to – the discussion surrounding prison officers' alleged role conflict in caring for prisoners at risk of suicide and self-harm (see section 4.1). Whilst these tensions and ambiguities may well extend to all or most aspects of nurses' and doctors' work in prisons, dealing with and caring for prisoners who self-harm may be particularly difficult for such staff, for at least three reasons. Firstly, and despite the official rhetoric of multi-disciplinary work and shared responsibilities (HMCIP, 1999), there is evidence to suggest that prisoner suicide and self-harm continue, in practice, to be seen as a "medical problem" (Howard League, 2003), and that healthcare staff maintain prominent responsibilities in this area. Secondly, treating self-inflicted wounds may significantly add to the "stress [of healthcare staff] related to the fear of exposure to hepatitis, HIV, or other chronic infectious diseases" (Flanagan & Flanagan, 2001, p. 70), particularly as prison populations tend to be at high risk of communicable diseases (*Ibid.*). Finally, nurses and doctors may respond especially negatively to prisoners who self-harm because of their "hybrid" status (Lupton, 1999) and "doubly-deviant" (Lloyd, 1995) identities.

Within medical settings, clients who self-injure, and especially those who do so in a chronic and seemingly non-suicidal way, are most often considered to suffer from multiple diagnoses, enduring mental health problems and, above all, 'personality disorders' (e.g. Breeze & Repper, 1998). Similarly, those who self-harm in custody may be perceived by medical staff as being prisoners (and hence potentially aggressive, demanding and manipulative) *and* mentally ill, personality disordered, and/or 'difficult/challenging' patients (Doyle, 2001; Flanagan & Flanagan, 2001). For instance,

in its influential report on nursing in secure environments, the UKCC (1999) discussed issues around self-harm under the subheading "practitioner-client relationships, challenging behaviour and the personality disordered client" (p. 10).

It has been argued that a hybrid identity (such as that of a prisoner *and* 'self-harmer') can be "all the more threatening [to staff] because its fluid and indefinite status prevents its classification under any one category" (Holmes & Federman, 2003, p. 951; see also Lupton, 1999). Furthermore, there is evidence that the label personality disordered carries a number of negative connotations, most notably that the patient is "non-sick", "manipulative" and "non-compliant" (Crowe, 2004, p. 328). Although there is no direct evidence relating to healthcare staff's reactions to self-harm, studies have shown that medical staff working in prisons hold negative views towards individuals with personality disorders (Carr-Walker, Bowers, Callaghan, Nijman, & Paton, 2004), as well as towards prisoners in general (Shields & de Moya, 1997). Prisoners who self-harm may thus be seen by medical staff as being doubly manipulative, difficult and challenging.

The causal chain of such representations is not clear, but it seems likely that such constructions and discourses will negatively influence medical practice and the relationships between healthcare staff and prisoners who repeatedly self-harm.

4.4 The Impact on Specialist Staff of Repetitive, Non-Suicidal Prisoner Self-Harm

Whilst the current knowledge of officers' and medical staff's responses to prisoner self-harm may seem limited, even less is known about the impact of this, or any other area of work, on specialist staff. This is perhaps unsurprising if one considers that research on work stress and attitudes amongst prison staff has largely overlooked "managerial personnel" (Reisig & Lovrich, 1998) (a notable exception is Owen, 2006, which, however, is of limited relevance to the current research), that the influx of outside specialist professionals into the prison world is relatively recent (see e.g. Liebling, Tait, et al., 2005; Schaufeli & Peters, 2000), and that such staff group(s) are essentially heterogeneous.

Although there is no official or agreed definition of specialist staff, this term may be used to describe staff from different grades, disciplines and professional backgrounds, who have a specific role with prisoners and/or other staff groups. In the present study, this definition was applied to those practitioners and others whose specialist role was to support self-harming prisoners and/or staff dealing with this issue. This included: the Governing Governor, Safer Custody Governor and Suicide Prevention Co-ordinator at the establishment, as well as members of the prison In-Reach Team, Psychology, Chaplaincy, the Staff Care and Welfare Service and the local Care Team (see glossary and appendix 7b for definitions and descriptions of professional roles).

Due to their different roles and responsibilities in relation to self-harm, and their varying degree of involvement with prisoners and/or staff affected by this issue, it would be unfeasible to attempt to produce an account of the impact of prisoner self-injury on all specialist staff. To do so was not only beyond the scope of the present study, but would also have seriously compromised the anonymity and confidentiality of the staff who were interviewed. In view of their very specific role, specialist staff may be easily identified and identifiable, particularly given that data for the current study was collected from a single Prison Service establishment.

Nevertheless, due to their specialised roles, such members of staff may feel particular pressures and anxieties when dealing with self-harm. Despite having generally less contact with prisoners who self-injure than landing staff, specialists have clear responsibilities and accountability in relation to self-harm, both of which are potential sources of work stress and burnout. Recent evidence also suggests that they may not benefit from the same level of support available to officers on the wings, and are often "forgotten", or excluded, from the critical incident debriefs which sometimes follow an incident of self-harm or a self-inflicted death in custody (Safer Custody Group, personal communication, 6th September 2004).

Specialists may also operate in a climate of hostility from landing staff (see e.g. Liebling, Tait, et al., 2005), poor resources, and, particularly where the most senior grades are concerned, of general frustration and discontent about the ways in which they themselves are governed. Carlen (2002), for instance, has argued that prison governors

are subject to - and, to some extent, victims of - an "overblown", "maverick managerialism", that manifests itself in a variety of unprioritised and fragmented policies, repeated restructurings, role redefinitions, reviews and criticism, "paper mountains" and erosion of governors' power and discretion. All of this is said to take place within the context of budgetary and security constraints "which necessarily make it impossible for them fully to implement *and* monitor the over-ambitious new policy programmes which have been introduced in recent years" (emphasis in original; p. 28).

All of these factors suggest that the experiences, issues and needs of specialist staff dealing with self-harm also require and deserve attention. Whilst it may not be possible to do so in a comprehensive manner in the context of the present study, it is hoped that this research may at least be able to raise awareness of their views and concerns. Their reactions to self-harm may not only have implications for specialists themselves and for prisoners who self-injure, but may also affect other staff groups working in prison. Specialists' own attitudes, knowledge and responses in relation to self-harm may greatly influence their ability to manage, support and supervise front-line staff (see e.g. Jordan et al., 2003; Rowan, 1994).

Furthermore, specialist staff tend to occupy relatively privileged institutional positions, which implies that they may have the power to make changes in services. Therefore, "this shift in 'gaze' is important in helping challenge services to examine themselves and their perceptions of gaps in services" (Burman & Chantler, 2003, p. 305). Focusing on the 'powerful' carries the additional advantage of diverting attention away from the 'objects' of policy (in this case, prisoners and front-line staff dealing with repetitive self-harm), hence avoids perpetuating their marginalisation, and the view that *they* are the problem to be addressed. Further, and in the words of Duke (2002), "research on these groups has the potential to expose the reach of power so that those subject to it can understand and challenge it" (p. 41).

4.5 How Do Prison Staff Cope with Repetitive, Non-Suicidal Prisoner Self-Harm?

Dealing with self-harm is thus a potential source of stress for prison staff. However, and in the words of Triplett et al. (1996, p. 294), "identifying possible sources of stress on the job [...] is only half of the problem. Examining how employees may effectively cope

with these stressors provides a more comprehensive understanding of work-related stress". Unfortunately, besides insinuating that staff may develop defensive negative attitudes towards prisoners who self-harm, previous studies have paid little attention to the ways in which prison staff cope with this area of work. As a result, there is currently little information available as to a) what, exactly, may underlie staff's negative reactions to self-harm, b) what can be done to address these, and c) what other, more positive, reactions exist amongst prison staff dealing with this issue. As highlighted by Bowers (2002) in relation to nurses working with "personality disordered patients" in high security hospitals, it is important to explore the ways in which staff dealing with complex and potentially stressful work situations manage, nonetheless, to "stay positive". This, in turn, is often equated with maintaining a caring attitude towards difficult and challenging prisoners/patients (whatever those terms may mean) (e.g. Barker, 2002; Maeve, 1997; Martin & Street, 2003; McAllister, 2003b).

In the absence of a developed model or account of how prison staff cope with repetitive, non-suicidal self-harm, the following section reviews current knowledge(s) and understanding of the ways in which staff deal with their prison work, *in general.* In doing so, particular attention is paid to factors and reactions which may be especially relevant to staff's responses to self-harm. Unfortunately, whilst it was possible to produce separate accounts relating to officers and healthcare staff, the literature on coping amongst specialist staff was insufficient to permit separate consideration. Nonetheless, some of the issues discussed in relation to officers, nurses and doctors are also likely to be of theoretical and practical relevance to specialist staff.

4.6 How Do Officers Cope with Repetitive, Non-Suicidal Prisoner Self-Harm?

Research on coping amongst officers, in general, is also scarce, both in terms of the extent of such research, and the types of coping explored (for a review of prison officers' coping mechanisms for dealing with work-related stress see Triplett et al., 1996). Despite some psychological research investigating the possible sources and the effects of work-related stress in prisons (e.g. Schaufeli & Peeters, 2000), little is known about the individual, group, or organisational resources available to prison officers "to prevent, avoid, or control emotional distress" (Pearlin & Schooler, 1978, p. 3). The limited literature on this topic suggests that officers use mainly passive, indirect and

palliative strategies to cope with the negative emotions that result from their job (Schaufeli & Peeters, 2000). Examples include "reducing on the job involvement" and "refusing to talk about work after hours" (*Ibid.*). Perhaps not surprisingly, these have been found to be largely ineffective in terms of reducing work stress, with the possible exception of positive comparisons across job types (but not over time). The use of social support systems, albeit a potential source of stress in itself (for a discussion see Clarke, 2004), has also been found to have direct, indirect and buffering effects on work stress (Triplett et al., 1996). Arguably, this is an area that warrants further investigation.

Overall, the psychological literature on coping among prison officers may be described as rather narrow in its focus, and methodologically flawed, particularly in relation to the measurement of stress and coping (Triplett et al., 1996). Therefore, its relevance to the present study may be limited. Potentially more useful contributions come from the also small - but growing - criminological literature on how prison officers cope with the "effects of prison work" (Arnold, 2005; see also Crawley, 2004; Kauffman, 1988). Unlike most of the psychological research in this field, these studies often employ qualitative methods, allowing researchers to explore issues around staff cultures, and their complex role(s) in relation to officers' adaptations to the demands of prison life - including prisoner self-harm.

4.6.1 Collective Coping: Prison officer culture(s)

Although variously defined, occupational culture has been broadly conceptualised as a collective coping mechanism (see Liebling, Tait, et al., 2005), developed, shared and socially transmitted among groups of people, in response to common problems or situations in the work environment (Paoline, 2001). As discussed in the previous chapter, the values, beliefs, customs and working practices entailed in such culture(s), can, in turn, "influence the quality of the regime, the 'tone' of the prison and the consequent relationships between prison officers and prisoners, and between officers themselves [and other members of staff]" (Crawley, 2004, p. 35).

Issues around staff culture emerged as a major theme in Liebling, Tait, et al.'s (2005) recent evaluation of the Safer Locals Programme, the latest (at the time of writing) set of interventions piloted in local prisons to reduce incidents of suicides and self-harm. This

research found the "traditional" culture amongst prison officers to be the key obstacle to the implementation of this new strategy. Drawing on the more extensive literature on "cop culture" (e.g. Chan, 1996; Reiner, 1992, 1997), Liebling, Tait, et al. conceptualise traditional officer culture (a term borrowed from the policing literature) as, at least in part, a coping mechanism in response to work stress, and, in particular, to staff's feelings of being undervalued by managers and their perceptions of their work environment – especially in relation to issues of safety, control and security. It is clear from the authors' description of traditional culture that strong adherence to it may "inhibit direct and indirect forms of support for prisoners at risk of suicide [and self-harm]" (p. 155). Some of its main features include "laying low" (which may lead to a reactive approach to prisoner care), distrust of outsiders and managers (which may hinder team work, and block "the efforts of non-uniform staff, particularly those with care roles" (p. 156)), and social distance from prisoners (with clear implications for the approachability of officers).

Liebling, Tait, et al.'s analysis suggests that traditional cultural values can predict the view of prisoner self-harm as manipulative and attention seeking. This appeared to be especially influenced by officers' relationships with prisoners, their levels of job satisfaction, and suicide prevention training. Furthermore, negative views of self-harm were found to be significantly related to institutional suicide rates. On this basis, the authors concluded that traditional staff culture mediates between staff distress and prisoner care. Unfortunately, whilst investigating the impact of staff distress and officer culture on prisoner self-harm, their analysis pays relatively little attention to the ways in which dealing with self-harm may, in turn, affect staff and staff culture.

Notwithstanding the significance of this study, some of its limitations are pertinent. Although the strategy being evaluated sets out to "pay more attention than previously to self-harm as a problem in its own right" (Liebling, Tait, et al., 2005, p. 1), this study seemingly follows in the tradition of focusing mainly, and almost exclusively, on *suicide* risk, rates and prevention. Also, despite acknowledging variations in staff culture between different establishments, the authors seem to avoid discussing issues around the multiplicity of cultures and "working credos" in prison (e.g. Crawley, 2004; Lombardo, 1989; Rutherford, 1993), within and amongst staff groups. It is not always clear from

their report whether the notion of traditional staff culture refers to the values and practices of prison officers, or of *all* staff working with prisoners at risk of suicide and self-harm. Either way, questions around individual and group differences remain largely unanswered.

4.7 How Do Healthcare Staff Cope with Repetitive, Non-Suicidal Prisoner Self-Harm?

The rather scarce literature on coping amongst prison healthcare staff has also tended to emphasise collective - but, regrettably, monolithic - responses to work stress and "difficult patients". Much of the available evidence, which mostly consists of first-person accounts and anecdotes about nursing in prison (e.g. Austin, 2001; Lynch, 1993; Willmott, 1994, 1997), describes the ways in which nurses, and, to a lesser extent, doctors, negotiate the difficulties of working in a prison environment, and the alleged tension between custody and care. In turn, this is often, rather simplistically, conflated as a "conflict" (Walsh, 2005) between ***punishment*** and care (e.g. Gadow, 2003), and, perhaps even more so, between doctors' and nurses' 'good' humanistic values and officers' 'bad' punitive culture (e.g. Doyle, 2003; Maeve, 1997). For the most part, these accounts suggest that healthcare staff cope with the anxiety of working with and caring for prisoners by assimilating officers' traditional culture, which then facilitates their relationships and integration with officers. It is therefore suggested that nurses and doctors deal with their "struggle" of caring for prisoners (Weiskopf, 2005) by *not* caring for them. In the words of Gadow (2003, p. 165), "the contradiction between care and punishment is resolved by the absence of care responsibility towards those who have made themselves intractably other". This may be especially the case when dealing with prisoners who self-harm, whom staff may perceive as being especially manipulative and, for that reason, may not "like or feel compassion toward" (Maeve & Vaughn, 2001).

Experts in the field have variously described this process as "Othering" (Maccallum, 2002; Peternelj-Taylor, 2004), negotiating "cognitive dissonance" (Festinger, 1957) and "switching off" (Sequeira & Halstead, 2004). Others have referred to prison nurses' and doctors' uncaring attitudes as a "distancing tactic" (Lupton, 1999) or an "avoidant coping strategy" (Sequeira & Halstead, 2004). However, and perhaps surprisingly, this process of gradual desensitisation and emotional distancing is seldom discussed in

relation to the high levels of stress and burnout amongst this occupational group (see e.g. Edwards et al., 2003; Flanagan & Flanagan, 2001; Happell et al., 2003), nor is it linked with the possibility that nurses' and doctors' *own* occupational culture(s) and prejudices may affect their practice. Rather, it is often suggested that the "goodwill and non-judgemental attitudes" of healthcare staff (Doyle, 2003) become "morally contaminated" (Holmes & Federman, 2003) as a result of working with "manipulative prisoners" (Maeve & Vaughn, 2001), and, even more so, with the "omnipresent" officers and their "penal harm mentality" (*Ibid.*). Maeve (1997), for instance, has referred to this as a clear example of the "pathogenic", "distorting and perverting effect prison systems have on the practice of nursing [and medicine]" (p. 495). Becoming *non* caring is thus described as an almost inevitable aspect of nurses' and doctors' "occupational socialisation" (Maeve & Vaughn, 2001).

As suggested by Sim (2002), whilst there is clearly an awareness of "the issues of staff culture and its detrimental impact [...] this insight remains underdeveloped", particularly in relation to "the impact of the wider culture on particular staff" (p. 316). Arguably, these accounts risk creating a static, over-generalised and overly deterministic picture of how healthcare staff cope with and adapt to working in different prisons and with different prisoners. Whilst it is important to recognise the structural pressures and constraints facing medical staff working in prisons, and their collective reactions to such difficulties, to also explore how these are constructed, resisted and dealt with at a micro-level may produce a more complex and sophisticated understanding of doctors' and nurses' responses to prisoners, and allow for a more dynamic reading of prison nursing and medicine.

Focusing on *individual* coping strategies amongst prison healthcare staff may be especially useful in the context of the present study. Whilst there is no direct evidence relating to self-harm, Carr-Walker et al. (2004) found that, with regards to personality disorder (the diagnosis most frequently received by people who self-harm), "organizational, environmental and training differences do not necessarily result in more negative attitudes of nurses [...] individual aspects of personality, background or previous experiences of prisoner/patients with personality disorder could have a greater influence on their attitudes" (pp. 272-4). Regrettably, the authors failed to discuss, in any

depth, what these individual factors might be; nor have other published studies dealt with this topic.

Another limitation of the existing literature on coping amongst prison healthcare staff is that it seemingly ignores the positive impact, if any, of officers' traditional culture, or the ways in which the healthcare ethos, with its interconnected web of ideologies and formal and informal practices, may, in turn, influence and dynamically interact with the wider landing culture(s). This seems to be a more plausible idea than the suggestion that nurses' and doctors' occupational culture(s) become completely absorbed and incorporated into officers' traditional culture.

In addition, the story of the caring, passive and powerless nurse is not consistent with evidence that prison healthcare staff are *more* negative than officers towards personality disordered prisoners (Carr-Walker et al., 2004), and prisoners in general (Shields & de Moya, 1997), or the recurrent finding that nurses and doctors working *outside* prisons may also respond to patients in uncaring ways – particularly where people who self-harm are concerned (see Ch. 3). Nevertheless, this essentialist, rather romanticised image of healthcare staff cannot and should not be ignored, as, in itself, it may represent a means by which correctional nurses and doctors cope with their work in prisons.

The dichotomy between the caring nurse and the bad, punitive officer, on the one hand, and "monstrous" prisoner (Holmes & Federman, 2003), on the other, may be described as a "tribal story", a "[professional] story the group members tell about themselves [...] to protect the individual and the group against anxiety" (Cooper, 2001, p. 36). As such, its significance "is not so much in whether it is true or untrue but in that it influences the care that is given" (p. 35). The popularity of this tribal story within the literature suggests that it may "have become so routinized, mundane, and banal to pass for standard operating procedure" (Maeve & Vaughn, 2001, p. 55). Therefore, it is important to critically consider and deconstruct these accounts. To this end, it is useful to draw on "Foucauldian readings of nursing" (Gastaldo & Holmes, 1999), which have convincingly challenged the idea that nurses are fundamentally powerless[12] and caring

[12] For instance, the image of nurses as (always and all) powerless and passive victims of the system has come under scrutiny, and has been criticised as a disempowering "disciplinary tactic [...] for ensuring the

(see e.g. Holmes & Gastaldo, 2002; Hopton, 1997), that caring is good, and that custody, punishment and care are essentially antithetical[13]. Moreover, it has been argued that there are different types and levels of care, and different ways in which this concept can be produced, negotiated and resisted at an individual and collective level (see e.g. Austin, 2001; Barker, 2002; Maeve & Vaughn, 2001).

Over recent years, there has been growing discussion in the literature of the ways in which prison healthcare staff may indeed resist (some of) the negative influences of officers' traditional culture, and reconstruct the care they provide in prisons. Above all, this is thought to involve embracing the "paradox" of their professional roles and identities (Gadow, 2003), "getting closer to the patients" (Holmes & Federman, 2003) and repositioning oneself as a "curious and compassionate onlooker" (Cooper, 2001). According to Maeve (1997, p. 508), "this appears to be accomplished by a process of identifying with inmates, relationally", and as human beings, which, in turn, are thought to require adequate levels of staff training, support and clinical supervision (see also Ch. 8).

However, most of these accounts are aspirational, prescriptive models of how prison nurses and doctors *should* deal and interact with prisoners. Perhaps inevitably, they reflect different ideas as to what may constitute a positive, caring and therapeutic response, and for whom. Very few studies have empirically tested these models or explored the ways in which prison healthcare staff may actually manage to 'stay positive'. Although the wider literature on nursing has highlighted some of the "beliefs, moral commitments, skilled interpersonal actions, cognitive self-management strategies, specific applied knowledge, and skilled teamwork" (Bowers, 2002, pp. 145-146) that may help staff (outside prisons) to respond to patients in positive ways, there is evidence that these may not necessarily be relevant, effective or practicable in the context of

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nurse's alignment with the dominant discourses [defined as patriarchal discourses of management and medicine] within the clinical setting" (Crowe, 2000, p. 964).

[13] Within this framework, both punishment and (pastoral) care have been conceptualised as "disciplinary techniques", aimed at the regulation and/or self-regulation of individuals. "[W]hether their role is (or should be) concerned primarily with therapy and actualisation or discipline and subjugation [...] nurses and doctors are engaged in the monitoring and containment of deviance. This is carried out through surveillance of behaviour [...], incarceration, enforced administration of treatment, the use of human force and mechanical restraint, and 'in house' physical and social exclusion – i.e. seclusion" (Morrall & Muir-Cochrane, 2002, p. 1).

prisons. As commented by Bowers (2002), "the organisational context can support or hinder their use" (p. 91). Clearly, this suggests that there is a need for research to look at how nurses and doctors (and other staff groups) negotiate their care for and *with* (Barker, 2002) prisoners.

To this end, it may be useful to focus on the concept of prison masculinities. This may not only contribute to our understanding of nurses' and doctors' willingness and ability to care for prisoners who self-harm, but also of officers' (from whom healthcare staff are said to 'absorb' their uncaring attitudes), and of all other staff groups working in prisons. Although Liebling, Tait, et al.'s (2005) traditional officer culture is, in many ways, a 'macho' culture, theories of masculinities have been largely neglected by this, and other studies conducted in this field. A notable exception is Crawley's (2004) ethnographic study of "doing prison work". Unfortunately, despite the author's stated aim to explore the "emotional life of prisons *on a day-to-day basis*" (emphasis in original; p. 130), her research only deals with the emotional impact of prison suicides on officers, and neglects the more day-to-day issue of repetitive self-harm. The next section will therefore briefly review the literature on masculinities in prison, and discuss its relevance to the present research (see also Ch 1.8).

4.8 Masculinities in Prison

Prisons have been described as the most male-dominated of modern institutions. Consistent over time and across almost all countries, around 90% of adults in prisons are men (Newton, 1994; NOMS, 2006; Walmsley, 2006). Prison staff are also predominantly male (Cowburn, 1998). On this basis, it has been argued that relationships between and amongst staff and prisoners, and the very "social order of the institution" are "sustained and reproduced not only by the organisational demands or rules of law, but also through deeply embedded discourses around masculinity and femininity" (Hsu, 2005, p. 3). Indeed, according to Carrabine and Longhurst (1998, p. 164), "the manifestations of power in such relations are likely to involve the construction and reproduction of masculinities".

Previous prison-based literature also suggests that the masculinities dominant (or "hegemonic" (Connell, 1995)) in prisons are "hard case" masculinities, that define

themselves through the assertion of strength and the rejection and suppression of femininity and of everything gentle, spontaneous, soft, and relaxed (Segal, 1990, p. 116; see also Jewkes, 2005). Machismo, dominance, authoritativeness, and aggressiveness are thought to become so central to the occupational culture of (male and female) prison staff, and their successful job performance, that "the prison officer who cannot muster some version of this masculine image before both inmates and peers is in for trouble" (Crouch, 1980, p. 217). Clearly, this tough, "hypermasculine" ideal (Newton, 1994) has implications for the ways in which staff respond to male prisoners who self-harm.

The "cult of machismo" (Ryder, 1994) dominant in prisons is in conflict with staff's caring and supportive role in relation to prisoner self-harm. Research suggests that demonstrations of care, sympathy and concern for prisoners - which are traditional female emotions - are deemed culturally inappropriate amongst officers, and are therefore censored (see e.g. Liebling, Tait, et al., 2005). This, in turn, may affect the attitudes and ethos of other staff groups working in prisons. Those who do express these feelings may experience guilt or distress, and acquire what Goffman (1963) terms a "spoiled identity". Indeed, Crawley (2004) argues that "sympathy for the prisoner" is the emotion possibly most in conflict with the occupational norm of prison officers (see also Kauffman, 1988), whilst Maeve (1997) has suggested that prison nurses are "in substantive ways, ordered not to care" (p. 495). This may be particularly the case when dealing with prisoners who repeatedly self-harm with no apparent suicidal intent. By engaging in what is traditionally constructed as a feminine activity, these prisoners may be seen to display "subordinate" masculinities (Connell, 1995). Furthermore, the dominant view of self-harm as a controllable manipulative gesture (see Ch 3.1.1), may influence staff to believe that these prisoners are especially unworthy of such emotions.

However, this is not to suggest that staff do not *feel* these emotions, but rather that they operate within a culture that does not encourage the direct expression of (non-masculine) emotions (Arnold, 2005; Towl & Forbes, 2002). In the prison setting, the construction of an authoritative, confident and dispassionate masculinity may not only influence how staff respond to prisoners in distress, but also the ways in which they manage their *own* emotions. In other words, it may hinder their ability and willingness to offer support to prisoners in distress, on the one hand, and to seek support for themselves, on the other.

This may lead staff, and perhaps particularly officers, to "perform courage, confidence and indifference on a day-to-day basis" (Crawley, 2004, p. 142), which often entails an intense degree of "face work" and masculine "impression management" strategies, including the use of humour, strategies of depersonalisation, and a rhetoric of coping and detachment (*Ibid.*). Indeed, as discussed in Chapter 2 (see especially section 2.2), this "macho" ethos of emotional control is likely to affect staff's interactions with the researcher, and their 'performances' during the interviews.

Nevertheless, and whilst not wishing to reinforce negative stereotypical accounts of the brutal and insensitive prison guard, Crawley (2004) also comments that "not only do prison officers learn not to show compassion towards prisoners (except in specific circumstances), many also learn not to feel it" (p. 36). Over time, the cultural expectation to be "hard" may influence officers to become "harder". As a result, "what is at first bizarre and frightening becomes normal, routine" (p. 185). Arnold's (2005) research suggests that this is very much related to the effects on staff of dealing with incidents such as attempted and completed suicides, and 'serious' self-harm. Due to the unpredictable nature of these events, and of the reactions they may evoke in officers, this gradual numbing of feelings is said to become an adaptive process, a "test of prison officers' survival" (Arnold, 2005, p. 411). Unfortunately, Arnold fails to discuss the ways in which this macho ethos of emotional control is likely to be affected by ongoing, yet lower level incidents of self-harm.

Most of the work on prison cultures and masculinities, including Arnold's (2005), Crawley's (2004) and Liebling, Tait, et al.'s (2005), has been conducted from a macro, sociological perspective. Less is known about how hegemonic and subordinate masculinities are constructed, resisted and negotiated at the micro, psychological level. "What is missing is more fine-grained work" (Wetherell & Edley, 1999, p. 340). Rather than merely categorising groups of staff into broad types "depending on their shared collective positioning in relation to gendered practices", it is important to address questions around:

> What happens psychologically? How are norms conveyed, through what routes, and in what ways are they enacted by men [and women] in their daily lives? Are they the same in every social situation? Does everyone

know what counts as hegemonic all the time? How is hegemony conveyed interactionally and practically in mundane life? (*Ibid.*, p. 339)

This type of approach may reveal the internal tensions, contradictions and fissures of hegemonic forms of 'macho' masculinities in prison, and hence expose what Sim (1994) defines as "other, empowering and positive patterns of behaviour [that] have developed as a challenge to traditional networks of domination and subordination" (p. 101).

4.8.1 Changing Prison Cultures and Changing Masculinities

Despite prisons being traditionally - and rather simplistically - described as "ultra-macho" environments (e.g. Cowburn, 1998; Newton, 1994), it is important to point out that prison masculinities are non-essentialist, dynamic and continually contested. "Dominant ideas about masculinity *are* subject to change, linked in particular shifts in power and politics" (Ruxton, 2002, p. 4; emphasis added). In recent years, the changing of this work culture has been explicitly identified as a priority in this area, key to implementing a "healthy" prison (HMCIP, 1999) and reducing rates of suicide and self-harm in custody. In this context, "culture change" has primarily been described as "a shift in the willingness and ability of staff to care for prisoners" (Liebling, Tait, et al., 2005, p. 197), a move towards the "Care" end of the "Care and Control" spectrum (Safer Locals Evaluation - Terms of Reference, 2001; as quoted in Liebling, Tait, et al., 2005, p. 1).

In spite of what the prison nursing literature appears to suggest, the discourse of care, and the associated notions of 'support' and 'relationships', seem to have become increasingly popular in academic debates and official Prison Service rhetoric (so much so that the old "strip cells" are now called "care suites", the old segregation units have become "care and separation" units[14], whereas the new form to record incidents of self-harm is called "Assessment *Care* in Custody and Teamwork" (emphasis added) – when previously it had just been a "Self Harm 2052 Monitoring Form", often shortened to the number 2052). Less is known about the effects of these recent changes on staff's (or

[14] From a more cynical perspective, it may be argued that the re-labelling of "segregation" units serves to legitimize the deplorable practice - seemingly still in use at the time of writing (see e.g. Lord Carlile, 2006) - of segregating prisoners who are "at risk" of suicide and self-harm.

prisoners') cultural practices and discourses. It would be naïve to suppose that 'sensitive' and 'caring' masculinities have become dominant in prison, but it is clear that they exist, and that charting them has the potential to challenge rigid, monocultural notions of male hegemonic attitudes. As argued by Hearn (2004), in order to deconstruct the ways in which masculinities are produced and reproduced, we need to consider:

> The various and variable everyday, natural(ized), ordinary, normal and most taken-for-granted-practices [...] and their contradictory, even paradoxical, meanings – rather than the depiction of the most culturally valued ideal, or the most exaggerated or over-conforming forms of men's practices. (p. 61)

Important though they may be, prison masculinities are by no means the only cultural influences on prison staff's responses to self-harm. Foucauldian models of nursing (see Gastaldo & Holmes, 1999) suggest that, in contemporary healthcare practice, issues around care, and its alleged conflict with security and custody, may not be as pressing, relevant or paradoxical as many have suggested. The pervasiveness of managerialist discourses - both within the penal system (Carlen, 2002; Scheerer, 2001) and the healthcare profession(s) (Rose, 1996) - suggests that issues around 'risk' may be of equal if not greater pertinence to the current study. The establishment in recent years of actuarial measures and key performance indicators (see glossary) for suicide and self-harm in custody, and the current emphasis in Prison Service policy on "managing risk" and "focusing [...] where the risk of suicide and self-harm is highest" (HM Prison Service, 2001, p. 4), implies that the discourses and politics of risk may be of great relevance to all staff groups working in prisons, and their responses to self-harm. Therefore, the struggle and/or focus of prison staff dealing with self-injury may not be so much on 'curing', punishing or caring for those who self-harm, but rather on the "monitoring, reporting and control" of such ("deviant") behaviour, "to best meet the fiscal needs of the organisation" (Crowe & Carlyle, 2003, p. 19).

Where repetitive and non-suicidal behaviours are concerned, the enduring tendency to refer to prisoner self-harm in terms of its seriousness may also affect staff's attitudes and reactions. Despite official recognition that "an act of self-harm should *always* be taken seriously" (HM Prison Service, 2003, para. 3.1.2; emphasis added), there is evidence

that prison officers tend to distinguish between serious (or major) and minor incidents of self-injury. The same dichotomy is not uncommon in the literature (e.g. Arnold, 2005; HMCIP, 1999; Liebling, 1992), and in Prison Service policy (e.g. HM Prison Service 2003, 2004c). In spite of its current usage, the notion of serious self-harm has no clear or agreed definition. Both in research and practice, many have tended to shy away from providing an exact definition (e.g. HM Prison Service, 2003), whilst others have used this term to refer to the seriousness of the method, intent or medical severity of the self-inflicted harm. Nevertheless, a widespread assumption is that the seriousness of an act of self-harm is a) related to the medical severity of the self-inflicted injury (or injuries), b) indicative of how "genuine" the incident is (Camilleri et al., 1999), and thus c) of how much "risk" it may pose in relation to suicide.

Based on these criteria, many incidents of non-suicidal and repetitive self-harm would probably be described in prison circles as *not* being serious. Whilst distinguishing between different types of self-harm is generally considered to be useful, both in research (e.g. Favazza, 1996; Warren, 1997) and practice (e.g. HM Prison Service, 2001), the notion and the semantics of seriousness are arguably counter-productive (Dexter & Towl, 1995; Snow, 1997). As reported by Snow (1997), "those prisoners who were deemed to engage in less serious self-injury were dismissed [by staff] as attention-seeking and manipulative" (p. 58). The labelling of a self-harming incident as 'non-serious' may stigmatise prisoners, as well as belittle the stress and anxieties involved in working with prisoners who self-harm. In turn, this may have the effect of devaluing staff and leaving their professionalism unappreciated.

4.9 Refining the Research Design

Previous research suggests that staff dealing with prisoners who repeatedly self-harm with no apparent suicidal intent are likely to be adversely affected by this area of work, and to react to these prisoners in negative ways. This can have important implications for the lives and work of prison staff, not least of which for their crucial role in the prevention and management of self-harm in prisons (Dexter & Towl, 1995; HMCIP, 1999; Power et al., 1997). However, staff's responses to this complex behaviour have been treated rather superficially in the literature. Most of the (few) studies dealing with this topic have tended to *describe*, rather than *explain* and/or *deconstruct*, staff's

reactions to self-harm. This type of approach offers limited implications for policy and practice, and is potentially counterproductive. By reinforcing negative stereotypes of the "brutal and insensitive guard" (Crawley, 2004), these studies may heighten feelings of discontent amongst prison staff, which may further exacerbate the problem.

Recent discussions of staff, and especially officers' attitudes towards prisoners who self-harm have begun to explore how and why the broader context and content of prison staff's job(s) may render dealing with self-harm stressful. However, to-date there has been no systematic, in-depth examination of the impact on prison staff of working with male prisoners who repeatedly self-harm, with no apparent suicidal intent. As a result, little seems to be known - if not at a speculative level - about the experiences, issues and needs of officers, healthcare and specialist staff in relation to this specific area of work.

The present study aims to increase knowledge and awareness of the effect(s) of repetitive, non-suicidal self-harm on these different staff groups, on both a personal and professional level. This includes:

1) What are the experiences, views and reactions of prison staff working with adult male prisoners who repeatedly self-harm, with no apparent suicidal intent?

2) How do prison staff deal with this area of work? What coping methods do they employ?

3) What impact does prisoner self-harm have on the lives and work of prison staff?

It is useful to address these questions both at the micro and macro level. This involves a) exploring prison staff's *individual* experiences, understandings and training about repetitive, non-suicidal self-harm, and discussing how these factors may affect the ways in which they respond to prisoners who engage in such behaviours; and b) investigating how wider occupational and organisational forces affect the ways in which staff make sense of, and cope with repetitive, non-suicidal self-harm. Nonetheless, it may be difficult to discuss these separately, as they are likely to be interconnected.

In turn, answering these questions also entails deconstructing staff's views and reactions, hence addressing the following questions:

4) How do prison staff construct the notion of male, repetitive, non-suicidal self-harm? What standard, hegemonic meanings are produced in these constructions? What inconsistencies, tensions and struggles (usually concealed) do they reveal? What meanings are obscured, silenced, and resisted?

Previous research suggests that answering these questions depends, to some extent, on addressing the subsidiary question of how prison staff construct the notion of 'serious' self-harm.

5) What are the functions and implications (for practice and subjective experience) of staff's constructions of male, repetitive, non-suicidal self-harm? What "subject positions" (Davies & Harré, 1999) do they offer? What possibilities for action – and non-action – do they afford?

6) What wider discourses and narratives do they drawn on?

A review of the literature suggests that, in answering this question, it may be particularly helpful to explore the ways in which gendered discourses (including discourses of machismo and emotional control, and discourses of care) and the politics of risk may be implicated in staff's responses to male, repetitive, non-suicidal self-harm.

Thus, the current research is not only interested in *what* are the experiences and reactions of staff dealing with this complex behaviour, but also in *why* staff may come to develop and exhibit particular attitudes and responses, and *how* these are constructed, resisted and negotiated in talk. Arguably, "*how* respondents interpret their lives is as important as *what* they report" (Redley, 2003, p. 351).

At the same time, this study aims to explore the effects of these responses on men who harm themselves in custody, from the perspectives of the prisoners themselves. In other words:

7) How do male prisoners perceive the reactions of staff (and different groups of staff) to their repetitive, non-suicidal self-harm?

In addressing this question, it is also useful to explore how prisoners themselves construct their self-harm, and their being 'self-harmers'. In turn, this may increase our understanding of how men in custody negotiate the "subordinate" forms of masculinity (Connell, 1995) that may be associated with engaging in what is traditionally constructed as a feminine activity.

8) What impact do staff's reactions to repetitive, non-suicidal self-injury have on prisoners and their self-harming behaviours?

9) How do male prisoners report wanting staff to respond to their self-harming behaviours? What type(s) of reaction do they consider to be useful, and what do they perceive as unhelpful? What other support, if any, would they like to receive in relation to their self-harm, and more generally?

In view of the current problems of overcrowding and under-staffing affecting prisons in England and Wales, it may be helpful to explore what prisoner interviewees consider to be practical and achievable staff reactions and forms of support, as well as what may be viewed as ideal.

This also applies when investigating issues around support for staff working with prisoners who repeatedly self-harm, in seemingly non-suicidal ways. As discussed in Chapter 3, the are a range of interventions, systems and processes that may prevent or reduce the impact of self-harm on workers, for the potential benefit of clients who self-harm, the staff dealing with their complex needs, and the organisation for which they work. Having explored in previous research (Marzano, 2004; Marzano & Adler, 2007) what sources of support are available to prison staff in dealing with self-harm, this study aims to address questions around the use, effectiveness and potential value of these different interventions (including "concrete support with the work itself" (Fillmore & Dell, 2000, p. 74), training, peer and managerial support and ongoing supervision for *all* staff - rather than only healthcare staff). In so doing, this research hopes to:

10) Increase awareness of the need to support staff working with prisoners who repeatedly self-harm, with no apparent suicidal intent;

11) Further our understanding of how prison staff can be most effectively supported with regards to this area of work;

12) Discuss the ways in which adequate staff support may help to counter negative practices and discourses in relation to repetitive, non-suicidal prisoner self-harm.

These key areas and questions – as well as those raised by participants themselves – guided the analysis of the 58 interviews conducted as part of this research. Over the next four chapters, the accounts of staff and prisoners are discussed and interpreted in relation to these aims, juxtaposed with analyses of relevant literature and policy, and their implications for the latter. In particular, Chapters 5 and 7 consider the experiences and reactions of staff dealing with prisoner self-harm (points 1 to 7), whereas Chapter 6 focuses on the views and concerns of prisoners engaging in self-harming behaviours (points 7 to 9). In contrast, Chapter 8 deals with issues of staff training, support and supervision in relation to this area of work (points 10 to 12), as part of a broader discussion of the viability of 'solving' the problem of negative staff reactions to self-harm. To formulate some general conclusions, the main themes discussed in these chapters are then brought together in Chapter 9, and considered alongside wider theoretical, methodological and political questions.

Chapter 5. Prison Staff's Constructions of Repetitive, Non-Suicidal Self-Harm

Having set the theoretical and methodological research context in earlier chapters, this is the first of four empirical chapters reporting findings from the staff's and prisoners' interviews. To address some of the research questions set out in section 4.9, this chapter summarises and discusses the main themes from the interview with 38 members of staff, on their views and experiences of dealing with repetitive, non-suicidal prisoner self-injury. Following a brief discussion of participants' definitions and classifications of self-harm, the chapter proceeds to consider what dominant and subjugated discourses existed around repetitive forms of self-injury. Dealing with each staff group separately, it presents the main types and typologies of "self-harmers" described by interviewees, trying to deconstruct some of the assumptions and "common truths" (Willott, 1998, p. 184) reflected in these themes. These themes are then drawn together in a wider discussion of how culturally available discourses may (re)produce and/or resist different implications and subject positions for prisoners who repeatedly self-harm.

Please note that in this chapter, and in the remainder of the thesis, direct quotations from participants are reported in double quotation marks, or as indented, single-spaced paragraphs. Participants' pseudonyms are provided when citing excerpts from their transcripts (please note that details of individual interviewees are presented in Tables 1 to 4 in Ch. 2.6-2.7. For ease of reference, an unbound copy of these is also included in appendix 7a). The numbers in brackets after each interview extract refer to line numbers from the full transcript (please note that the latter are only available to the examiners of this thesis – see Ch. 2.11.1), whilst the number in brackets within excerpts denotes the number of seconds of a pause (a full stop in brackets (.) indicates a brief (less than one second, but perceptible) pause). In sections dealing with one or more participant groups, the interviewee's staff group is also reported (please see glossary and (unbound) appendix 7b for definitions and descriptions of professional roles). The interviewer is indicated by the letter L. If the participant's pseudonym also starts with the letter L, the interviewer is indicated by the letters LM. Other key symbols and conventions to aid the interpretation of extracts are presented in Table 5 below (a full copy of the transcription notation is presented in appendices 5 and (unbound) 7c).

Table 5. Key Transcription Conventions

Words which are underlined were spoken with emphasis
Words in uppercase were uttered noticeably louder than the surrounding words
Words which could not be heard/understood during transcription are indicated by a lower case x per word
An uppercase X indicates a name of a person or place which cannot be given for the sake of confidentiality
A sigh or a loud intake of breath are indicated in the text by ..hh
An 'equals' sign at the end of a speaker's utterance indicates the absence of a discernible gap between speakers
A colon (breaking up a word) indicates an extension of the preceding vowel sound, or phoneme

5.1 Defining Self-Harm

When asked how they understood and defined the term 'self-harm', most participants provided broad definitions, encompassing a range of meanings and behaviours. Indeed, and particularly amongst officers, the causes, methods and severity of prisoners' self-inflicted injuries were described by some as being so varied as to make it "really hard" to define under one term. This recurrent theme was highlighted by Ian (officer), who commented:

> There are different forms, yeah. It can range from anything. It can range from physically hurting yourself to (.) cutting yourself, to starving yourself, to anything really. (33-34)

For this reason, the vast majority of participants seemed to avoid speaking of self-harm as a single category, and often made distinctions between different forms of self-harm. Only one interviewee, however, suggested that these may also include behaviours and practices that are ostensibly socially acceptable and "culturally sanctioned" (Favazza, 1996), such as smoking:

> But do they, I mean, do they, you know, misuse substances or alcohol? You know, x, that's also self-harm, isn't it? You know, smoking cigarettes it's also self-harm, you know. It depends where you define the line 'self-harm'. (L: um) you know. (Catherine, healthcare staff, 253-255)

5.1.1 From "Self-Harm" to "Self-Harmers"

Quite early on in the interviews, staff (and sometimes the researcher) tended to shift the focus of discussion from "self-harm" to "self-harmers". Arguably, this can have the effect of portraying prisoners as inseparable from their acts, and thus of constructing self-harm as something intrinsic in the individual, rather than - and regardless of - the environment (Groves, 2004). Indeed, this would explain Kevin's surprise, as he refers to a prisoner whose self-harming behaviour, "bizarrely", seemed to be influenced by his location within the prison:

> K: [...] By the way, that particular person, came back to prison, but wasn't sent to hospital, ehm, was made to stay on the main. Ehm, during his second time in prison. And for a good four months, got a job, worked, perfectly adapted. (L: um) never self-harmed. Miraculously (2) do you see what I (.) he came to prison, was deemed by one psychiatrist potential self-harmer (2) suicider. Was sent to hospital, and kept on self-harming. Left prison, came back (5)
> L: was not deemed to be suicidal=
> K: no. Not that much. Not much of a sort of a (2) you know, higher risk. It's, it's, it's {laughing} bizarre!
> (Kevin, officer, 183-191)

In addition, although the boundaries between certain types of self-harm were not always clear, self-harmers were mostly described as falling into rigidly distinct categories. This may not allow for the eventuality of an individual act of self-harm having multiple functions and meanings, or of a person self-harming for different reasons at different times (see e.g. McAllister, 2003a; Turp, 2002). Despite virtually all staff using broad and multi-dimensional definitions of self-harm, only one interviewee spoke of a prisoner "cutting himself to manipulate the system", as well as a way of dealing with his frustrations. All others referred to individual prisoners self-harming for one reason or another. For example the self-inflicted deaths, or near deaths, of self-harmers who were not deemed to be suicidal, were predominantly constructed as "pure accidents", rather than "genuine" attempts, due to an escalation of suicidality.

In many cases, these fixed categories of self-harmers were further constructed along rigid dichotomies, frequently expressed in terms of binary oppositions (e.g. "psychotic" versus "personality disordered", "mad" versus "bad", "attention seekers" versus "real"

self-harmers). This was often done with seemingly no recognition that these are neither essentialist categories, nor are they necessarily in opposition.

Along with others, Maccallum (2002) has contended that constructing dualisms is a form of "Othering"; it is deeply implicated in producing and maintaining power relations, not only between staff and prisoners who self-harm, but also between different types of self-harming prisoners. In other words, these dichotomies constructed a hierarchy of different categories of self-harmers as being more or less "real", "serious" and ultimately deserving of care and help (see also Chantler et al., 2001). For this reason, this chapter will not only discuss the main types of self-harmers described by staff, but also the ways in which these types were constructed along different dimensions of power; i.e. staff's typologies of self-harmers.

5.2 Officers' Typologies of Self-Harmers

For the purpose of this research, participants were asked about their experiences of dealing with "repetitive, non-suicidal self-harm". This was defined by the researcher as "chronic self-inflicted harm carried out with no apparent suicidal intent – regardless of the circumstances, method and/or severity of the injury or injuries". However, officers seemed to mainly focus on the repetitive element of this construct, which some also referred to as "habitual", "constant", "prolific", "perpetual", "active", and "conscious" self-harm. In contrast, issues around suicidal intent were side-stepped, often from the outset, as ten officers (along with eight healthcare staff and two specialist staff) appeared to believe all self-harm to be non-suicidal.

5.2.1 Self-Harmers and "Suicidals": It's the "quiet ones" who "just do it".

The very notion of repeated attempts to take one's life was challenged by the recurrent theme that prisoners who are "determined" and really "want" to kill themselves, "just do it". In this respect, suicide was not only - as a few officers described it - a "step up" from non-suicidal self-harm, but was mainly constructed as a fundamentally different phenomenon, involving different people. Indeed, Harry spoke of self-harmers and "suicidals" as being "two completely different things" (147-148). In particular, suicidal

prisoners were recurrently portrayed as being "quieter" about their intentions, and not giving "anybody a clue at all" (Gavin, 66).

5.2.2 Non-Suicidal Self-Harmers

Aside from the "suicidals", the main ways in which self-harmers were described by officers were as the "mentally ill", "the poor copers", and the "attention seekers", who were in turn constructed as "inadequates" and/or "manipulators". An example of this popular typology of self-harmers is presented in the extracts below:

> Some of them are habitual self-harmers, taking their frustrations out on themselves; erm, others for attention; others have got some personal problems, that need sort of addressing [...] Others would do it for real reasons, to try and kill themselves. (Jonathan, 61-67)

> I have the impression that it's different, there are different self-harmers, and (.) some have learnt from their time inside that it's a good way to get what you want – so it is a form of manipulation. I think others, ehm, probably suffer so much, ehm, inside that (.) you know, physical pain is their means of release (um), and that, that internal suffering (.) you know, I had a prisoner tell me that after a while it's like a buzz. You know, after (1) it, it releases something. (Erik, 198-203)

When commenting on self-harm, in general, officers tended to draw on each of the themes described above, although to varying degrees. For example, Carol spoke very little of the "manipulation" theme, and expressed her anger at people who embrace this "stereotypical view". Nonetheless, she also commented that it is, or can be "a fair comment", and that "a limited amount of people do it, do it for that reason" (397-398). Similarly, despite branding all self-harmers as "attention seekers", Bernie mentioned hearing that "it could be a release [...] to a certain extent" (182-184).

5.2.3 "The Ones Who Do It Repeatedly": The "attention seekers"

However, when officers were asked to comment on repetitive self-harm, a new, and recurrent, theme emerged: "prolific self-harmers" were not only described in terms of the functions of their behaviour (as were 'other' self-harmers), but also in relation to their "draining" effects on staff's patience and resources (see also Ch. 7.1). "Time wasters", "constant drain" and "pain" were only some of the negative labels used by officers to describe this group of prisoners. Moreover, when discussing repeated forms

of self-harm (as opposed to self-harm *in general*), there seemed to be less of a tendency to differentiate between different types of self-harmers. In ten interviews, prisoners repeatedly self-harming were constructed as an almost monolithic category: the "attention seekers". Whilst other themes were still present, they were often used to describe a small minority of more "genuine" self-harmers.

Rather than self-harming for "lots of different reasons", most, and at times, *all* "prolific self-harmers" were described as "doing it for attention", which was often said to be neither a "real" nor a legitimate reason. Indeed, this was often equated with "playing games", a metaphor implying a) that prisoners who self-harm may be in no pain or distress, but may be doing so "only just for boredom", for "a distraction" or "a buzz"; and b) that staff may be being played and manipulated by prisoners (which, as discussed in Ch. 7, may legitimate a more negative and sceptical response to such prisoners):

> It just annoys me when they are just, like, for attention. Because I just think, that's just a big game. I don't like it. (L: um) especially when they are supposed to be men. (Norma, 186-187)

5.2.4 "Manipulative" Attention Seekers

An often related theme was that most self-harmers "know" exactly how and when to self-harm, in order not to "actually" cause themselves any pain, "make it look genuine", "make the most disruption", and, above all, manipulate staff and the system into giving them what they want. According to Bernie:

> It's too easy [...] it's a cry for attention (.) ehm, I'll get myself on an ACCT form, and then everyone can pussy-foot around me, and if I don't get what I want, I'll say that I'm gonna cut up, and I'll find someone that do it for me then. And that's the impression that seems to come across. (137-140)

In this context, seeking "attention" was not only constructed as an end in itself, e.g. in terms of having some care, "conversation" and attention from staff, but also - and seemingly more often - as trying to get staff's attention in order to obtain something else. This theme was reflected in the accounts of 13 of the officers interviewed:

> Mostly (6) persons self-harming they always want some form of attention from it, they always want something from it. There's no one that I've known that would self-harm, and they don't want, you know, do I have to have a conversation, or if they are like mentally ill, or disturbed (.) they are always somebody that, FROM MY experience, that will self-harm, that will say to you 'I'm going to cut up'. I mean, ehm, ehm, the famous phrase

> is 'I'm going to cut up. I'm going to cut up if you don't do this, if you don't do that. I'm going to cut up' [...] So I think the function for them is just to have that bit of attention. (Frida, 353-364)

The "something" for which prisoners were alleged to self-harm was often described by interviewees as "silly little things", ranging from tobacco, to a phone call, and, above all, drugs and/or medication. Indeed, in eight accounts, attention seeking almost became synonymous with drug/medication seeking.

5.2.5 "Oh, He's Just after Drugs": "Drug users" versus "real" and "mad" self-harmers

Drug users were not only thought to be the largest group of "attention seekers" in the prison, but also to be responsible for the vast majority of episodes of self-harm, for some up to 90 or 95%. Indeed, Harry pointed to drugs and the growing number of "addicts" in prisons as the main reasons why "the problem" of self-harm in custody is gradually "getting worse and worse". Moreover, as explained by Norma, drug users may self-harm for many, often related, reasons:

> I would say 70% would be to do with drug stuff. Like they are not getting their drugs, or they have been on drugs and now they are withdrawing, or ..hh they want subutex, which isn't the same – it's a blocker so it's not giving them the same buzz, do you see what I mean? O:or (.) they've got into drugs in here, and now, you know, they owe stuff, do you know what I mean? (L: yeah) it's all related to drugs. (199-203)

Overall, however, officers spoke relatively little of the reasons why "drug addicts" and "users" would self-harm for more drugs or medication, possibly because issues around detoxification and the administration of medication (which often seemed to be conflated) were seen as being outside their competency and duties.

Moreover, in virtually all cases, self-harming as a way to obtain drugs or medication was not seen to be a real or legitimate reason, nor did it seem to attract much sympathy from staff. Most of the officers interviewed spoke quite openly of the difficulty of remaining "patient" when a prisoner was alleged to be constantly self-harming "just" for drugs or medication. In turn, this seemed to be related to how "drug addicts" tended to be constructed amongst officers, regardless of their self-harm. Previous studies have reported that prison officers tend to show little empathy for those addicted to illicit

drugs, possibly because of their limited understanding of their needs (Loucks, 1997), and "the health and safety risks" which working with them may pose for staff (McIntosh & Saville, 2006, p. 237)

Predominantly described as "manipulative", drugs users in general (including prisoners seemingly self-harming for drugs) seemed to be set apart from the "mental patients [...] who have genuine problems and cut up". In Harry's words:

> They are just attention seekers, they are taking away from the real problem, people who have real problems. We have people here, drug addicts, who are cutting up literally to get drugs, and that's as simple as that. And to me, we shouldn't be giving into them, bu:ut (.) (93-96)

Their not being "mental patients" appeared to position prisoners repeatedly self-harming "to get drugs" as rational, and thus responsible actors, whose drug taking was "their own fault" (Norma, 752), as well as "what turns them into criminals" (Matthew, 716).

5.2.6 "Crying for Attention"

On the other hand, officers were not necessarily more sympathetic towards prisoners who were *not* thought to self-harm for "drugs" or "to manipulate the system". Even when their "seeking attention" was conceptualised as a "genuine" "cry for help", this was often demoted to being "just" a "cry for attention", for which many admitted having little time - in both a literal and figurative sense.

Six interviewees described prisoners repeatedly "crying for attention" as "whingers" and "losers" who "can't do their time". This, in turn, positioned them as "inadequate", not only as prisoners, but also as "grown men". Matthew, for example, referred to them as "soft lads", whereas Norma emphasised that self-harming for attention is not something a "proper blokey bloke" would do. According to Luke:

> I think the majority of cases are (.) cries for help. It's, it's so obvious. They can't, 9 times out of 10 they can't cope [...] which I think the majority of people think - that if you cut yourself you are weak, and you're a loser and you can't cope. (519-520, 699-700)

Whilst focusing on their being "poor copers", staff seemed to pay little attention to *what* prisoners might be having difficulties coping with, and why. Although for nine officers

all or most types of self-harm were essentially a way of drawing attention to one's "problems", there was rarely much discussion of what these problems were. For instance, only one officer argued that prisoners who self-harm may have a history of sexual abuse - which, indeed, was one the most recurrent reason cited by the prisoners themselves. Moreover, throughout the whole fieldwork, this was the only claim that a participant seemed to feel the need to defend and corroborate ("it's not just what he tells you. There is, there is official evidence to support it" (Kevin, 380-381)).

When prison-related issues were cited, officers often felt that this was not a legitimate reason for self-harming; having "done the crime", prisoners should now "do the time":

> It's like, you are doing that because you are, you are moaning about your situation. But you put yourself in that situation [...] GOD, YOU ARE A MAN, for god's sake. You are a grown man. You put yourself in a situation. You had choices, and took these choices. Take responsibility. Take responsibility for your actions, and just deal with it. Deal with your time. (Norma, 419-428)

Erik commented that this sentiment was especially strong as he had often witnessed prisoners "whinging" about trivial things, for example "because their television broke down or they didn't get to their yoga class on time, or their acupuncture" (505-506). These complaints were compared to the "real" pressures and difficulties faced by staff, at a time when - as many pointed out - resources and morale where at an all time low (see also Liebling, Tait, et al., 2005). This idea was also discussed by Ann, who suggested that a lot of prisoners, including "repetitive self-harmers", fail to appreciate officers' efforts, and their own role in creating a stressful environment for both prisoners and staff.

> Even if we try to do the best for them they can't appreciate what we are trying to do with the resources that we do have [...] They see it as 'I am a prisoner. I am entitled to this, and I'm entitled to that' (L: Mmm), and they don't appreciate where we come from. So they are always putting in complaints against us, and that puts us under pressure, and it puts us under stress. But they don't think about that, ehm, they don't think about that. (Ann, 31-32, 259-262)

Only in four instances was the "decision" to self-harm as a cry for help described (perhaps more sympathetically) as being constrained by the isolation and loneliness of prison life, linked with staff's (often unwitting) inability to provide prisoners with the

care and support they would like to receive, or with "human beings'" understandable and "natural" desire to "have a one-to-one [...and] build a rapport" (Frida, 342-344):

> You think about it, you are sitting in a cell, right? Your cell mate has gone out, he may (.) he's gone out to, I don't know, hospital for the day. And you are a self-harmer. You've got no telly. You've got nothing. Sitting looking at four walls. I need some human contact here. Because it's natural for a human being to want to have contact with another human being (.) it's the animal in us. [mimicking a prisoner cutting his arm] ring my bell. I've got human contact, ain't I? Somebody's going to come in. They are going to touch me, right. Come on (.) they are going to put something (.) they are going to take me to see a nurse, where I'm going to feel comfortable, safe (.) and I've got my human contact. Until tomorrow, then I'll do it again. (Luke, 1390-1398)

5.3 Healthcare Staff's Typologies of Self-Harmers

Although at times differentiating amongst different acts of self-harm (often also including "para-suicide" and "threats" to self-harm), medical staff tended to describe prisoners who self-injure as a more or less homogenous group, particularly when referring to those repeatedly self-harming. Moreover, distinctions between different incidents of self-harm were mainly based on degrees of medical severity and methods used; the functions, causes and meanings of these acts were seen to be relatively consistent. Once again, seeking attention emerged as a dominant theme.

5.3.1 Prison Self-Harmers versus Non-Prison[15] Self-Harmers

This, however, is not to say that self-harm *per se* was necessarily constructed as a one-dimensional concept. Lee, for instance, suggested that:

> There are different categories of self-harm. Some of them are just attention seeking, ehm, measures. Others are actual self-harm, because of what they are feeling – not because of they want you to do [...] But here, ehm, it's the the tradition or the, the, the picture usually is 'oh. I want this. I want this and that. And if you don't do it I'll hurt myself'. (44-57)

Lee's account highlights two recurrent themes. Firstly, that there are indeed different types of self-harm, in turn associated with different types of self-harmers. Secondly, that it is particularly - and, for some, *only* - in "this environment" that self-harm stops being multi-faceted, as well as "actual", "genuine" self-harm. Nine interviewees implied that "self-harm within the prison set up is not the same as self-harm outside" (Lee, 291), with

[15] Including secure units, hospitals and community settings.

three of them remarking that "patients" - particularly women - who self-harm outside prison do so for more varied, valid and "real" reasons, most notably "hearing voices" and having "really really serious issues" (Fay, 228).

5.3.2 Self-Harm as a Gendered Issue

In four cases, gender emerged as an important dimension of the inside vs. outside (prison) dichotomy. Not only was self-harm described as a gendered phenomenon ("such a young female kind of thing to do" (Hazel, 337)), male self-harm was often seen as being almost exclusively a prison phenomenon. Compared to those self-harming outside prisons (who were almost inevitably said to be women), prison self-harmers and male self-harmers in general were constructed as being less "genuine" and having less "serious" issues. Both seemed to be almost automatically – and uncritically – denied a victim status, and to be excluded from the perhaps more sympathetic discourses and systemic frameworks used with regards to women. In Fay's account:

> When you look at it, in most cases women who self-harm have got like really really serious issues. Most of them is like things that have happened to them in the past, and everything [...] Whereas with men, you find that some men it's just like, sometimes it's just like minor issues, and then they will start to self-harm. Because, to be honest with you, it was my first experience in prison, to see a man self-harming. (442-450)

Only once was self-harm explicitly constructed as a male - and macho - prerogative. This, however, appeared to be a particularly negative conceptualisation of self-harm, which located it within a behavioural (Corbett & Westwood, 2005) and moral (Groves, 2004) framework:

> Because, with, with the culture, and the criminal set up (3) is to be able to show that you are stronger than, you are macho and x. You have a lot more control of things than the rest. So if you are able to get more medication [through self-harm] you are seen as an actual (2), real, real dude. (Lec, 251-253)

5.3.3 Self-Harm in Prison and *in the Community*

The only exception to this otherwise rigid inside/male/"minor" and outside/female/"real" dichotomy was represented by the minority of prisoners who were said to self-harm in more than one context:

> Of course there are lots of people that they do self, self-harm when they are outside as well. And these are usually the people [20% of prisoners who self-harm] that it's their way of managing their problems [...] So that's completely something else. Not manipulating anybody. And sometimes when they are inside here it's, it's sort of the way to tell to somebody that things are not right. (Nathan, 103-109)

However, what was noticeably absent from this, and all other accounts, was the suggestion that individuals may only self-harm when in custody because they might be feeling more isolated or distressed than they would outside prison. Disregarding the potential effects of prison culture, regimes and of staff themselves on self-harm, participants tended to focus on internal, dispositional factors, and to construct "prison self-harmers" as intrinsically different from "community self-harmers". Even the four participants who acknowledged the potential role of environmental influences appeared to suggest that self-harm in custody owes its unique (and negative) characteristics to its unique population. In Lee's words, "it's quite a complex issue, compared to self-harm in other environments. It's different. Self-harm in prison [...] Because of the group of people we are dealing with" (502-505). Indeed, according to Hazel, this may explain the high rates of self-harm recorded amongst criminals:

> If they want something that's enough of a reason to have it. They tend to be quite, ehm, self-obsessed and, ehm, more of x. And also x not xx other people so much. So I think that's, kind of fits in with the self-harming personality? (L: um) kind of getting really really in-ward looking and only into yourself, and other people's feelings don't matter, because yours are more important, and (3) or even xx feelings, but xx. (L: um) just people that commit crime fits, kind of all clicks together a wee bit. (363-368)

5.3.4 Overruling Prisoner Discourses: The demanding and manipulative prisoner

When discussing issues around prison self-harmers, ten healthcare staff appeared to focus on their prisoners' identity more so than on their being self-harmers. In other words, although predominantly referred to as "patients", those self-injuring in custody were often positioned as prisoners first, and then as self-harmers. Indeed, even when asked very specific questions about their experiences of dealing with self-harm, staff would frequently drift into discussing wider aspects of their work at the establishment and with prisoners in general.

Healthcare staff's constructions of prisoners (and thus prisoners who self-harm) were in turn associated with two main discourses: a moral one which positioned prisoners as abusive and intimidating "bad people"; and an arguably more positive - but not incompatible - one which brought attention to the high percentages of individuals with "maladaptive coping skills", "narrow" "thinking styles", mental health and substance misuse issues within the prison population. Whilst these two discourses may have different premises and implications - most notably in terms of the level of agency, control and rationality ascribed to self-harmers - they both tend to construct prisoners as a potentially demanding and manipulative group of people, who would often stop at nothing to obtain what they want. This finding is consistent with previous accounts of prison nursing and medicine (see e.g. Flanagan & Flanagan, 2001; Shields & de Moya, 1997), which have conceptualised this as one of the main causes and/or manifestations of the "distorting and perverting effect prison systems have on the practice of nursing [and medicine]" (Maeve, 1997, p. 495). Those amongst them who self-harm were seen as no exception, and indeed were often said to be especially "challenging" and "draining". Arguably, this may be linked with interviewees' tendency to describe prisoners who self-harm as *also* being "personality disordered" (see following section), which may construct them as being 'doubly difficult' and manipulative (see Ch. 4.3.1).

This seemed to be reflected in the recurrent assertion that "90% or 80% of self-harm in prisons are basically due to demands" (Lee, 503-504), and the notion that prison self-harm is something one does to get a response from someone else. This, in turn, meant that participants' emphasis was rarely *why* prisoners self-harmed, but, in Oscar's words, "what for?".

In this context, drugs and medication emerged, once again, as dominant themes. Eleven interviewees commented that:

> There are those who do it, as I said, just for attention – when I say attention it's not so much attention, it's like their detox is finished? (L: right) and they feel "no, I need more dru:ugs". So that's the way of, the doctor giving them, for another period. (Jane, 168-170)

> They are attention seeking [...] ehm, I understand that most of them do it because there is something that they want (um), and [...] yeah, they do it

> because, ehm, they want something, which is mostly medication. (Maria, 410, 55-58)

5.3.5 "It's More of a Psychological Thing": The "PDs"

However, as in the accounts of most officers, the "real" issue was neither the prisoners' drug addiction, nor the prison's programme of detox being "shorter, (2) [and] in not so much quantity than the one in the community" (Anthony, 124). Rather, the problem is that *they* cannot take the pressure like "normal" people do. Indeed, even when prisoners were thought to be self-harming "just" as a "cry for help" (rather than to "regulate" medication), this was often said to be due to:

> Many of them being inadequate in their, in their person, in their person really (.) to deal with issues that, of ordinary life that other people would easily understand, you know, accept, and then they won't, you know. (Peter, 87-89)

Therefore, whilst the issues with which they had to contend were often dismissed as being "ordinary" and almost irrelevant, self-harmers were (implicitly or explicitly) pathologised and positioned as "abnormal". Indeed, the psychological inadequacies to which Peter and eight others referred were frequently constructed as a "pathology of the personality" and located within a psychiatric discourse. This was perhaps especially the case where repetitive self-harm was concerned. For instance, when asked specifically about chronic, non-suicidal forms of self-harm, Anthony commented:

> Well that's, that's more to do with the psychiatric side of things. You know, that's with a personality disorder, that's causing the person to self-harm. (94-95)

Similarly, six others clearly identified all or most self-harmers as suffering from a personality disorder:

> Most of them, ehm, they've got personality disorders. So it's very very difficult to manage PDs, we call them PDs. Because it's all about attention. It's like children. If I want something and you don't give me, I'm going to self-harm. It become habitual, as you were saying [...] Whenever things don't go their way, you know? Even (2) just normal people – I'm not saying they're abnormal – but just normal people; things don't always go our way. But with them it's like if things don't go their way or if their needs are not met immediately, then they'll self-harm. (Fay, 138-151)

According to this discourse, self-harming seemed to be simultaneously a cause and a consequence of being "PD": individuals who self-injure were labelled as "PDs", and

those who have a personality disorder were, by definition, said to self-harm. For Gareth, however, this is a "fact":

> I'm (.) not like to stigmatise anyone or maybe, you know, label them, but that is a fact, that 90% of people who are personality disordered will self-harm to try and get you to do. You know, they will try and manipulate themselves, to the system, to like, to, you know, to be noticed that, you know, I'm present. And try and get the medication. Ninety per cent of the time is about medication anyway. (122-126)

In spite of this, the label "PD" seemed to be held as a satisfactory explanation for self-harm, so much so that, every time it was used, no further or more in-depth accounts were sought:

> I just don't really xx. Some of the time I don't understand why they do it. What they do, but (.) ehm, it's a personality disorder more than anything. (Anthony, 201-202)

The identification of most prisoner self-harmers as "PDs" was also linked with the recurrent assertion that such prisoners are not "unwell as such":

> I mean in psychiatric nursing you get, you tend to hear a lot these opinions from nurses that (2) they don't mind if someone is genuinely psychiatric unwell, they are mad, and they are psychotic, and they are doing things, or maybe trying to hang themselves, hurt themselves because they are (.) psychotic and they are directed by voices [...] It's, you hear all the nurses say 'I don't mind that. I just can't be bothered with these people that (.) aren't unwell as such, and just want to get themselves attention' and all that kind of stuff [...] Other people xx have got psychiatric conditions; but it's more of a psychological thing, isn't it? (Hazel, 74-78, 321-322)

In turn, this implied that, despite such "psychiatrisation" of self-injury (Clarke & Whittaker, 1998, p. 133), prisoner self-harm was not strictly speaking a medical or psychiatric problem. Indeed, whilst the idea that prisoners who self-harm may be "genuinely psychiatrically unwell" was relatively common amongst officers, this was often resisted by nurses and doctors, who contended that prisoners would sometimes learn to mimic symptoms of psychosis and drug withdrawal in order to manipulate staff. As suggested by Breeze and Repper (1998), the denial of a "sick role" (Parson, 1951) - i.e. the idea that "patients' 'challenging' behaviour was not due to a mental health problem" (Breeze & Repper, 1998, p. 10) - may lead to them being labelled as "difficult", with important and "inevitable" implications for the care they might receive (or not).

5.4 Specialist Staff's Constructions of Repetitive, Non-Suicidal Self-Harm

Specialist staff appeared to draw on many of the themes that had emerged from the interviews with officers, doctors and nurses. Like most other interviewees, participants in this group tended to provide broad definitions of self-harm, and, in all cases but one, to distinguish between suicide attempts and self-injury. Hillary, Anita and Gail also made distinctions between male and female self-harm, whereby women were again said to self-harm "a lot more than men", and "for more complex" issues. Once more, these gender differences were closely intertwined with an outside versus inside (prison) dichotomy.

Also (re)presented in the accounts of specialist staff were some of the more negative and potentially stigmatising constructions of self-injury put forward by nurses, doctors and officers. Ben, for instance, referred to self-harming as "clearly disturbed behaviour", whereas Hillary described it as "abnormal" and Anita "pathological". Gail suggested that prisoners who self-harm are "not sick" as such, whilst Frank and Enid emphasised that a *minority* of prisoners may self-harm to "gain something" and "regulate their medication":

> X is a prisoner who, for a long time, has been in now (.) he's not a horrible little man, but he knows that I know he's working the system. (L: um) and whilst we all, you know (.) whilst we know that he's (.) sort of wrapping us round his finger as it were; he will harm himself seriously? (Frank, 120-123)

Like many officers and healthcare staff, Enid also drew a distinction between "genuine" "poor copers" and attention/medication seekers. In her own words:

> There is prolific self-harmers that do it because of a mental illness, and, ehm, and a mental, a a a tendency; but there is also those that do it for a behavioural or a discipline issue, because they haven't got a mental illness, and they are doing it to gain attention OR it's a behavioural pattern, that, that needs to be broken. (344-347)

Drugs and mental health issues were thus once again highlighted as important, and possibly causal factors in self-harm; whereas "crying for help", "regulating medication", "coping" and "communicating" were all identified as possible functions of this behaviour. However, interviews with specialist staff also revealed some new themes, as well as some novel, and arguably more positive interpretations of themes that had

emerged from the accounts of medical staff and officers. These are discussed in the following section.

5.4.1 Self-harm as an Issue in Its Own Right

Unlike many other interviewees, specialist staff seemed to construct both self-harm in general, and repetitive self-harm, as issues requiring attention in their own right:

> I think that it's, it's a complex issue, ehm, repeated deliberate self-harm, which is not about suicide, which is about the person themselves. (Anita, 140-142)

Whilst officers' and healthcare staff's main apprehension with regards to self-harmers was that they might "accidentally" kill themselves, specialist staff also appeared to be concerned with the management and prevention of self-harm and "prolific" self-harm *per se*. Self-harm was thus not necessarily nor exclusively discussed as a risk factor or proxy indicator for suicide. Indeed, Craig condemned the fact that "our main concern often is to (.) keep the prisoner alive" (93); whereas Enid expressed her dissatisfaction with current policies and procedures, precisely because they fail to cover "what we actually do with prolific self-harmers" (332).

In addition, whilst the majority of other interviewees had spoken of repetitive forms of self-harm in especially negative terms, for most specialist staff these were symptomatic of particularly "deep issues". Rather than concentrating on the demands, often "silly", for which prisoners were alleged to self-harm, participants in this group appeared to be more concerned with the underlying causes of the behaviour. In other words, their emphasis was on *why* prisoners repeatedly injure themselves, not "what for". In four accounts this meant focusing on their past, rather than (or as well as) on the "here and now":

> I know I had a lot of experience in (.) dealing with them, ehm, and of course, usually those people who are chronic self-harmers are people who haven't just started self-harming in prison. So:o it's not, not a prison related problem. It's, it's a much deeper problem. And goes back, ehm, often to childhood [...] And, I mean, quite a high percentage of self-harmers are people, people who have actually been abused in childhood. (Craig, 75-88)

Whilst many interviewees had positioned staff as the possible and frequent victims of prisoners' self-harm, self-harmers themselves were now seen as "victims". As illustrated

in the extract below, this seemed to be associated with more positive staff responses, even when self-harm was conceptualised as being "just attention seeking" and "play acting":

> What we call regular self-harmers are people who are (.) play acting. Usually just attention seeking, if you know what I mean. (L: right) [...] And, ehm, when you actually get into them (.) a bit sort of, you know, the psychology bit of it, sort of why were you self-harming (.) you kind of – again, I'm not talking serious self-harm – and a lot of it, they will admit to being so totally frustrated with the system, they feel they not getting, ehm, listened to, they might be thinking the time, they are not getting the care they should be getting [...] Some of these guys, if you listen to them, ehm, they have had a pretty bum deal outside (2) you know, a lot of it isn't self-inflicted, ehm, and they found themselves in positions, for whatever reasons, where they took x and their parents, splitting up or whatever [...] Because, obviously they are not doing it for fun. (Hillary, 176-178, 207-211, 237-240, 285-286)

This discourse positioned self-harmers as being potentially and understandably desperate and needy, rather than calculated and manipulative – even when self-harming for drugs and/or medication:

> There is also, there is, I do believe in some cases, it is an attention seeking form, of gaining attention – and I don't think that is a negative. I think it is the only way that they express through their emotions that they need some input from staff, and some attention from staff; and that's the way they gain it. (Enid, 147-151)

5.4.2 Self-Harm as an Intra-Personal Coping Strategy

In four accounts, adverse past events, including childhood abuse and parental separation, were associated with issues of low self-esteem and poor coping (for further elaboration see Ch. 6.1.1-2). These, in turn, were thought to be crucial in self-harm, which was conceptualised as a (maladaptive) "coping mechanism", that "helps them get through life" (Craig, 58-59). This time, however, the emphasis was mainly on what self-harm may mean and "do" for the individual, as opposed to what he or she might be trying to achieve from others:

> Self-harm has various different functions, and the model that we prescribe to is that we see self-harm predominantly as a way of coping, and as a form of communication, and (.) whatever form that takes, it's it's the person's relationship with the self-harm that's what's important. A lot of self-harm in prison gets kind of labelled as being, ehm, sort of manipulative or attention seeking, but many of the people that we work with have self-harmed for (.)

> even outside prison (um), and a lot of the time is their response to distressing events, or (.) mental state. And they use the self-harm as a way of kind of soothing, coping, getting relie:ef, dealing with anger, dealing with emotions, dealing with loss, all sorts of issues. (Anita, 38-46)

For example, and in contrast to those who had spoken of this behaviour as a "way of getting at staff", Craig suggested that self-harming may be a form of self-punishment and a means to "release pressure", whereas Enid implied that it might be a way of gaining some power and control "over yourself, and not so much over your environment" (139-140). In turn, this was said to explain why some people self-harm mainly or exclusively when in prison, where "by definition [...] you have no control and no power" (Anita, 138-139). Not only does this conceptualisation challenge healthcare staff's rigid inside versus outside (prison) dichotomy, it may also help staff to feel less coerced and bullied through self-harm, and thus less negative towards self-harmers. However, as emphasised by Enid, this discourse was still very much subjugated and misunderstood amongst (wing) staff:

> Because it's what they are used to, it's what they feel comfortable with, and it's also what they feel safe with, which a lot of people don't understand. And staff find that quite a disturbing thought actually, but they do feel safe with it. It's, it's something they know, it's something they feel they can control. (169-173)

5.5 Discussion

The data presented here support Rayner and Warner's (2003) conclusion that "there are a range of explanations of self-harm that are culturally available and which can be drawn on differentially" (p. 315). Whilst also attempting to highlight how these available discourses may be negotiated and resisted at a micro level, the main focus of this chapter has been on how different staff *groups* may draw upon them.

Although officers, healthcare and specialist staff all drew on similar themes and discourses to describe different types of self-harm and self-harmers (e.g. the "mentally ill", the "poor copers", the "attention seekers", etc.), their typologies and hierarchies (Chantler et al., 2001) of self-harmers appeared to be rather different. Also, themes that were only marginal, if not absent, in the accounts of officers and healthcare staff tended to be dominant amongst specialists, and vice-versa. Each of these themes appeared to

have important implications for how staff positioned themselves and prisoners who self-harm. It is to these that discussion now turns.

5.5.1 Deconstructing the "Attention Seeking" Theme: "Poor copers" and "manipulative" prisoners versus "real" self-harmers

One theme that was especially common amongst officers and healthcare staff (but less so in the accounts of specialists) was the idea that the majority of prisoners who repeatedly self-harm are "attention seekers". Although this finding has been reported on a number of occasions (see e.g. HMCIP, 1990; Liebling, Tait, et al., 2005; Snow, 1997), the questions of what this label may actually mean or imply, or how it may be (de)constructed, has received very little attention. As argued by Bowers (2003a) in relation to the term "manipulation", this can result in there being "little available guidance for staff on how to construe this behaviour, or on how to manage it" (p. 323).

This study suggests that "seeking attention" is open to a number of readings, and can be situated within multiple, and at times overlapping, discourses. In some cases, this was conceptualised as being "just" a "cry for help". More often, it was constructed as an attempt to manipulate staff, mostly to obtain drugs and/or medication. Either way, prisoners self-harming "just" for "attention" tended to be constructed as being neither "genuine" nor "real" "self-harmers - nor, indeed, "real" men. Staff did not only undermine the "seriousness" of repetitive non-suicidal self-harm - as previous studies have suggested (e.g. Dexter and Towl, 1995; Snow, 1997) - but would often deny the very reality of these acts, so much so that some accused them of "faking" and "mimicking" self-harm.

As discussed by Groves (2004, p. 59), these different "diagnoses" construct self-harm as "either a moral or a psychological problem" – and self-harmers as being, at best, "genuinely" psychologically "inadequate", and, at worst, manipulative and intimidating. In the accounts of healthcare staff, these distinctions appeared to reflect the conceptualisation of prisoners as "bad" people and/or "poor copers", and were often superseded by an overruling psychiatric discourse, whereby prisoners crying for help and those manipulating staff for drugs were both positioned as "personality disordered" (but not "unwell as such"). In the accounts of officers, the label "drug user" was

employed in a similar fashion, often coming to represent the main – negative – identity of those who self-harm. Although both labels tended to be used in a rather circular and uncritical fashion, they seemed to be held as satisfactory explanations for self-harm. Very rarely did officers or healthcare staff appear to question what may lie behind a prisoner's drug use or personality disorder.

When staff did attempt to further 'explain' self-harm, the emphasis remained primarily on dispositional factors, and on the functions, rather than the environmental causes of prisoners' behaviour. Individualising – and thus de-politicizing – this issue can have the effect of neglecting, trivialising, and further silencing the experiences, motivations and distress of which self-harm "speaks" (Pembroke, 1991). For instance, many self-harmers were said to injure themselves "just" for boredom, tobacco or a phone call, with participants rarely questioning why prisoners would go to such an extent "just for silly little things" - possibly because of the common assumptions that they are not "really" hurting themselves, and do not feel any pain. Nor did most staff seem to consider how important those "silly things" might be for the prisoners themselves, or whether poor copers may actually have alternative ways of coping available to them (e.g. some made assumptions about prisoners having a family to support them, which, sadly, may not always be the case). As notoriously argued by Sykes (1958), even what may appear to be minutiae of prison life are part of the "significant hurts" and "pains of imprisonment", threatening prisoners' sense of self-worth:

> These frustrations or deprivations may be in the immediate terms of thwarted goals, discomfort, boredom, and loneliness, they carry a more profound hurt as a set of threats or attacks which are directed against the very foundations of the prisoner's being. (pp. 78-79)

As also discussed by Lord Justice Woolf (1991), these "little things" can significantly contribute to prisoners' sense of injustice, embitterment and helplessness. Both in prisons (see e.g. Haycock, 1989; Ivanoff & Jong, 1991) and outside (see e.g. Williams & Pollock, 2000; Williams, 1997), these feelings have been found to be associated with the risk of an individual self-harming and, potentially, becoming suicidal.

As a result of belittling prisoners' difficulties and "deprivations" (Richards, 1978; Sykes, 1958) and their potential effects, what may otherwise be constructed as a desperate or defiant "cry of pain" (Cresswell, 2005), often came to be described in pejorative terms as being "merely" a passive and potentially pathological "cry for help". This rather more dismissive conceptualisation of self-harm may be especially dominant in prisons, where the meaning and "seriousness" of this behaviour tends to be eclipsed by the priority given to suicides in custody (see Groves, 2004; Howard League, 1999; Rickford & Edgar, 2005).

Furthermore, by tapping into a number of "feminine myths" (especially passivity, masochism and primitiveness), the "cry for help" discourse has been argued to reinforce the notion of self-harm as a female, feminine and effeminate disorder (Brickman, 2004). In turn, this may have particular implications for men who self-harm. Particularly in a 'macho' environment such as prison (Newton, 1994; Ryder, 1994), it can create a paradox whereby men who express their feelings through self-harm are seen as weak, and those who do not want to appear weak may self-harm to make themselves "look strong", instead of "childishly" "screaming and shouting" to ask for support (Luke, officer, 524-528). To complicate things even further, those self-harming as a "cry for help" seemed to be encouraged to discuss their issues with staff (rather than self-harming) (as indeed set out by the current policy – see HM Prison Service, 2005a) which then made them not "real" self-harmers. "The real ones [...] mention their desperation just slightly" (Lee, healthcare staff, 302-303), if at all.

On the other hand, when self-harming was constructed in more "macho" terms (as in Lee's account – see section 5.3.2) and self-harmers were positioned as active and defiant agents, the implications for prisoners were as negative, if not even more so. Whilst (some) feminist literature has suggested that re-framing self-injury as a site of resistance may open up new, less individualistic and potentially more positive responses to self-harm (see e.g. McAllister, 2003a), this seemed to have the opposite effect. As commented by Bowen and John (2001, p. 367), "the expression of self-injurious behaviours may be labelled delinquent or aggressive within negative masculine constructs". Arguably, deconstructing male self-harm also involves challenging these "negative masculine constructs" and hegemonic notions of masculinity.

However, these negative reactions did not only seem to be associated with them being male, but also – and arguably more so – with them being prisoners. As such, they arguably need to be understood within the complex power dynamics – and power struggle – between staff and prisoners (see Ch. 4.2). In this context, the positioning of prisoner self-harmers as being, above all, *prisoners* (which was especially recurrent amongst healthcare staff) may serve to (re)produce and maintain an "us and them" dualism, and thus to construct those who self-harm as "Other". In the words of Maccallum (2002, p. 88) "the 'Us' and 'Them' phenomenon is an example of Othering. 'Them' are posited as 'Other', of less value than 'Us'". In turn, this may, once again, "steal their voices" (*Ibid.*, 91), particularly - as it was often the case - when them being prisoners (and therefore 'Other'), was located within retributive and "penal harm" discourses (Maeve & Vaughn, 2001). Ten officers and nine healthcare staff seemed to actively resist prisoners' rights and care discourses, and, in so doing, to rationalise, and simultaneously reinforce, the "less eligibility" (see Maeve & Vaughn, 2001; Sim, 2002) of prisoners who self-harm, the belittling of their needs and distress, and their own *not* caring (see also Ch. 7).

5.5.2 Alternative Readings: 'Positive', but subjugated, constructions of repetitive self-harm

Nonetheless, it is important to point out that the "attention seeking" theme was open to a number of readings. Although the "attention seekers" were constructed as being "poor copers", "mad", and more often "bad", there seemed to be "positive" and "negative" versions of each of these sub-themes. For example, whilst some would refer to prisoners "crying for help" as "childish" and "inadequate", others - albeit a minority - would describe them as "people who need support". Even prisoners who were considered to be "manipulative" were sometimes described in more sympathetic terms as people "needing some human contact" (Luke, officer, 1392). As argued by Bowers (2003b), "different ways of construing manipulative behaviour open the doors to positive emotional reactions" (p. 330).

Moreover, not all self-harmers were constructed as "attention seekers". Although they were said to be the minority, the "mentally ill", the "suicidals", and those who have "real deep issues" or use self-harm as a form of "release", tended to be described as

"genuine", "real", and even "understandable" self-harmers. Whilst these themes may also result in individualising and pathologising self-harm (see e.g. Groves, 2004; Johnstone, 1997), staff appeared to be more sympathetic towards prisoners who were positioned as "genuine", and frequently commented on their being more "deserving" and in need of help (which, however, they often did not feel personally able or obliged to provide – see Ch. 7.3). Arguably, this more positive reaction may stem from staff feeling that such prisoners are not responsible for their self-harming ("they can't help it" (Jane, healthcare staff, 110)) and/or that this behaviour is not directed at them ("the real ones most often they don't threaten you with self-harm" (Lee, healthcare staff, 302-303)). In addition, interviewees would sometimes refer to the issues of "genuine" self-harmers as being more "serious", but also at times more "solvable" than those of prisoners who are "just playing games", with the implication that these might be easier to "manage", as well as less "chronic". This, in turn, may lead to staff feeling more in control and optimistic about their work, and to experience a higher sense of purpose. As discussed by Mackay and Barrowclough (2005), amongst others, the extent to which an act of self-harm is judged to be "uncontrollable" (i.e. beyond the individual's control) and "unstable" is associated with positive affect in staff, as well as increased optimism and willingness to help.

It is important to trace these more positive - yet "subjugated" (Foucault, 2003) - ways of constructing self-harm and "attention seeking", particularly as this may inform the development of staff training. Regrettably, with the exception of five cases, these themes tended to receive only a brief and vague mention at the beginning of the interview, and then be developed no further – unlike more dominant attention/medication seeking discourses. For instance, staff rarely discussed what may constitute a "real" or "serious" issue, but simply stated that this was something "they don't want to talk about" (Jane, healthcare staff, 75). Also, the idea that prisoners may self-harm as a form of release (and thus for the effect it has on them, rather than on other people) was mentioned by nine officers and four healthcare staff, but, in ten cases, seemed to disappear, particularly when specifically discussing repetitive forms of self-harm.

Nevertheless, some of these themes were dominant amongst specialists. Unlike officers and healthcare staff, the latter seemed to focus on the psychological causes, as well as

the functions of self-harm. This located self-harmers within a more sympathetic 'victim' discourse, whilst emphasising that their behaviour (however maladaptive) may be useful and meaningful – and not (or not only) in terms of manipulating other people, but predominantly in terms of managing one's own emotions (intra-personally rather than inter-personally).

The idea that self-injurious behaviour may be a sign of distress, and, at the same time, something that enables people to "cope" with and "survive" their problems (however maladaptively), has long been celebrated and encouraged in the "survivor" (Cresswell, 2005) and penal reform literature (e.g. Howard League, 2001). Not only does this offer a (seemingly) more sympathetic reading of self-harm than the more dominant attention seeking discourse, it also opens up the possibility that self-harm may be a form of self-care and "self-soothing" (McAllister, 2003a), rather than something to be stopped at all costs.

5.6 Conclusions

Whilst not wishing to categorise any staff group as being "good" or "bad", specialists appeared to be rather more positive and sympathetic towards prisoners repeatedly harming themselves. In contrast, the majority of officers and healthcare staff who took part in this study positioned most "prolific" *prisoner* self-harmers as being "bad" and/or "poor copers".

Even within each group, interviewees tended to speak of other staff as being either "good" or "bad" in relation to this area of work. However, virtually all participants seemed to draw on a variety of different themes and discourses. Regardless of how one might conceptualise them, "good" and "bad" frequently co-existed - though often in different proportions, and in a very rigid manner. Whether this might be good enough is, however, a different matter.

Although the majority of staff interviewed said to treat "prolific self-harmers" just like any other prisoner (which was not necessarily positive), and to always (or mostly) remain "professional", the previous literature suggests that negative labels can have important implications for the level of care staff may be able - or willing - to provide.

For example, in her discussion of "Othering" in forensic practice, Peternelj-Taylor (2004) has highlighted that derogatory labels, such as "manipulative", can become "superimposed on the nurse's common theoretical representation that a patient is a person for whom care is provided [...] When a patient's behaviour is interpreted solely as manipulative, caregivers will respond negatively to that patient's needs" (p. 136).

Chapter 7 will explore some of the possible functions and reasons for the different readings of self-harm put forward by staff (and different staff groups), by focusing on the potential impact of this issue on staff themselves, and locating these themes within the wider context and content of their work. The following chapter instead considers the implications of these different conceptualisations and "banter" about self-harm, for prisoners who self-injure. Drawing on the accounts of 'self-harmers' themselves, it explores the ways in which different ways of constructing and responding to those who injure themselves in custody may influence their well-being, and, potentially, their self-harming behaviours.

Chapter 6. In the Prisoners' Words: Being a Prisoner 'Self-Harmer' - Experiences, motivations and interpretations of staff's responses.

This chapter reports the main findings from the interviews with 20 adult male prisoners, on their experiences of self-harming - and being 'self-harmers' - in custody. Having explored the perspectives of staff in the previous chapter, the focus is here on how the men themselves understood their self-harming behaviour, and its causes, functions and meanings. In order to address the research questions set in Chapter 4 (see Ch. 4.9), and given the paucity of research, and particularly of participant-centred experiences of repetitive, non-suicidal self-injury (see Ch. 1.3), the first part of the chapter reports how the 20 prisoners constructed, resisted and negotiated their identity as 'self-harmers'. In the second part, the attention shifts to a) how the men perceived different staff groups' responses to their self-harm, and b) how they felt these reactions affected them and their self-injury. Lastly, some practical and theoretical implications are considered.

Please note that, to avoid excessively broadening the focus of the thesis, and exceeding the imposed word limit, it was not possible to develop and discuss all of the themes that emerged from the data (see Ch. 9.5.1). Rather, prisoners' accounts are mainly discussed in relation to the staff data, and previous psychological and prison-based literature.

6.1 Prisoners' Constructions of Repetitive, Non-Suicidal Self-Harm

6.1.1 Challenging Attention/Medication Seeking Discourses: "Vulnerable" men, the (un)healthy prison and self-harm

Perhaps unsurprisingly and, as indeed shown by previous studies (both in prisons and outside - e.g. Harris, 2000; Loucks, 1997; Reece, 2005), many of the men interviewed accused staff of not understanding, and/or not wanting to understand, their self-harm. Implicit in many accounts was the contention that staff failed to appreciate both the meanings and the causes of their self-injury, and thus failed to "see it how it is". For Stephen, this meant that they did not only trivialise his self-harm, but also belittled and de-humanised him, reducing him to "just a piece of paper":

> Do you just think I'm just a piece of paper then? Oh, he's a 2052 – that's another one (.) in the drawer. What's that all about? It's all, it's all (2) you

> know, all this stuff, the files and (.) is that it? I'm a piece of paper – is that all I am? Just a bit of pain in the paper, do you know what I mean? I'm not interested in that. I'm more than that, do you know what I mean? I'm a human being. I'm, you know, I like being (1) open, and honest. I'm an honest person. I mean, it took me a long time to tell people my background, where I come from, but [...] They are not interested in what they've gone through, they are interested in what's occurring, all the time. They are just interested in (.) crime, or why they do it, they are not interested in being back (2) in the x. Because you think, what's happening there is why I'm doing it now. (1056-1070)

Like Stephen, many others brought attention to the backgrounds and "imported vulnerability" (Liebling, Durie, et al., 2005) of people who self-harm, and prisoners in general. Indeed, Andrew suggested that, despite prisoners self-harming for many different reasons:

> They all come from disruptive backgrounds. People who have been abused – mentally, physically and sexually. xxx (L: yeah). All come from (5) abusive backgrounds [...] and there are so many types of abuse, you know. Like, it doesn't have to be contact abuse. As a child you can just be ignored, that's abused isn't it? xx there's all sorts of abuse. And mine was the worse sort I think. Which makes it quite understandable that I grew up {laughing} with a few disorders! (435-444)

As implied by Andrew, and as indeed shown by the so-called risk literature (see Ch. 1, especially section 3.4) all of the prisoners interviewed came from what may be considered difficult and disadvantaged backgrounds. Five of them discussed having received and/or witnessed "serious beatings" from a young age, and six spoke of having been raped as children, in three cases by family members. Four had been placed into care, and three described having been in and out of prison for much of their lives. Having alcoholic, mentally ill, absent and neglectful parents were also frequently mentioned, as were issues of abandonment and loss. For example, George witnessed his mother's murder at the age of eight; Fred was almost killed by his own mother, whereas Bill found his mother hanging when he was only 14. Six others described their struggle at trying to come to terms with more recent bereavements and traumatic events, and, in each case, linked these with suicidal thoughts and behaviours. Many also spoke of their family responsibilities and their concern for their young and, in one case, unborn children. Whilst seemingly an important protective factor for suicide and self-harm, missing one's children and family appeared to be a cause of deep sorrow, particularly perhaps for the two foreign national prisoners in the sample. As well as being unable to

see or speak to their families and friends whilst in prison, Carl and Mark reported experiencing isolation, racism and language barriers.

In view of these backgrounds, it is perhaps unsurprising that four of the men interviewed reported recurrent flashbacks, two others said they suffered from depression and two more from panic attacks. Five had been diagnosed with a personality disorder, and nine described themselves as "drug users" (with four more having abused drugs in the past). Whilst this may seem to validate the claims of the officers and healthcare staff interviewed, it is important to note that these labels were constructed as additional ways in which their problems manifested. They were not seen as causing self-harm. "Drug problems" and psychiatric conditions were described as "understandable from what I went through" (Richard, 190), and as being not *the* reasons, but "*for* the same reasons I do the cuts" (Leo, 220-221; emphasis added). Although in two cases withdrawing from drugs was implied to be causally linked with self-harm, drugs and medication were more commonly described as having similar causes, functions and effects as self-injury. Arguably, the relationship(s) between drug addiction, requests for medication, and self-harm is much more complex than that suggested by many of the staff interviewed.

The stories of these 20 men clearly challenge staff claims that male prisoners self-harm for "silly little things", and highlight issues that are gradually being recognised in relation to women in custody (e.g. HMCIP, 2005; Loucks, 1997), but seem to continue to be overlooked in relation to adult men (a noticeable exception being Rickford & Edgar, 2005). Whilst frequently recognising that self-harm may be seen as both "silly" and a sign of "weakness", and not denying their being unable to cope or control themselves, being "junkies", "selfish" and "childish", wanting (or needing) medication and so on, the men interviewed contextualised their 'inadequacies' within the grim realities of their lives inside and outside prison. For at least half the participants, this served to re-conceptualise self-harm as a coping mechanism or, for some, the *only* way in which they had "adapted to cope [...to] the situations I've been in my life since I was a kid" (Leo, 253-254). This theme has long been discussed - and celebrated - in feminist psychological accounts of women's non-suicidal self-harm, both in prisons (e.g. Fillmore & Dell, 2000) and outside (e.g. Spandler & Warner, 2007). This 'victim/survivor' discourse shifts the attention away from the individual deficiencies of

those who self-harm to the reasons behind their being "poor copers" (Toch et al., 1989), and the difficult feelings and events with which they are admittedly struggling to cope.

At the same time, these discourses raise the question of whether staff and the wider penal system might be the ones unable to deal with the demands of their growing and vulnerable population(s), rather than self-harmers being the pathological "poor copers" (see also Smith, 2000; Thomas et al., 2006). Indeed, healthcare staff and officers were often branded by interviewees as "plain horrible", untrained, "ignorant", "racist", negligent and always too "busy":

> I don't think they are, I'm not slagging the officers off or nothing, I know they've got a job to do but I don't think they're really geared up for it. (Kieran, 205-207)

In addition, the men's perceptions of "safety", "respect" and "purposeful activity" in the prison - three of the four so-called "tests of a healthy prison" (HMCIP, 2004) - were often poor. According to Jack, it is "no wonder" that rates of suicide and self-harm are so high in this "sick" and "messed up" environment:

> Because it's disgusting, the way they treat people on the mental health side of things. It's a joke. It really is a joke. Do you know what I mean? No wonder there is so much suicide and self-harming in these places – not just this place, in all of them. Do you know what I mean? I can't, I can't believe, I mean, you can't believe the way that they treat you. (217-221)

6.1.2 Making Sense of Self-Harm: Causes, triggers and functions of repetitive self-injury

Seven interviewees made direct links between their histories of trauma and abuse, and their self-harming behaviours. For Leo, "[the sexual abuse] that's where it all stems from. That's where I learned that behaviour" (416-417). This finding has been reported on an number of occasions within psychological accounts of (women's) self-harm outside prisons, and interpreted from psychodynamic (e.g. Gardner, 2001; Miller, 1994), bio-social (e.g. Van der Kolk et al., 1991), and systemic (e.g. Babiker & Arnold, 1997; Chantler et al., 2001; Spandler & Warner, 2007) perspectives. Whilst the precise nature of these links continue (perhaps unsurprisingly) to be debated (for a review see Connors, 1996), their role in the aetiology and repetition of self-injury has been described as "strong and direct" (Hawton, Rodham, & Evans, 2006, p. 80). Although predominantly

researched in relation to women, the association between sexual abuse and self-harm has been found to be even more profound for men (*Ibid.*). In this light, the predominance of this theme in the prisoner data may be seen to bring little surprise, but its almost total absence in the accounts of officers and healthcare staff (see e.g. Ch. 5.2.6) is arguably concerning.

This, however, is not to say that traumatic and abusive events were always held to be a reason, or the *only* reason behind the men's self-harm. Factors associated with being in prison were also frequently cited as causes and, perhaps more often, *triggers* for self-injury. These included: feeling unsafe, bored, isolated and unsupported (particularly in relation to medical and detoxification issues), as well as being "teased", "brushed off" and "bullied" by prison officers. Having nobody to talk to and feeling desperate or worried about problems inside or outside prison were also mentioned. For reasons of central focus and word count limits, these themes are not explored here in any depth (see Ch. 9.5.1). However, it seems important to note that these findings are consistent with those of research on suicidal self-harm in prisons (e.g. Liebling, 1992; Medlicott et al., 2004), and women's non-suicidal self-harm (e.g. Loucks, 1997; Snow, 1997; Wilkins & Coid, 1991), but fail to lend support to the scant literature on male non-suicidal prisoner self-harm (see section 6.1.6 for further elaboration).

Although according to Donald "it's always for a reason" (421), the men's motivations for self-harming were not always clear or clearly defined. Some of them described injuring themselves "in some kind of rage" (Richard, 708) and/or in a dissociative state (see also Fickl, 2007; Frost, 1995), whereby one "can't catch the difference between reality and his dreams" (Mark, 68-69). Far from being a rational, calculated action (cf. Ch. 5.2.4), self-harming was thus described as an impulsive act, something that "just happens" (Oliver, 392), and that they could not always understand, "predict" or rationalise. Harold, for example, spoke of "finding" scars on his arms and not even realising that he had self-harmed until later, whereas Leo kept questioning himself as to why, as a "grown man", he continued to "resort to that sort of behaviour"(183-184):

> And you go and get your razor blade. I mean you go and you don't know what you are going to do with it. Sometimes you don't mean it, but, do you know what I mean, you do x. Do you know what I mean, miss? And that sometime I can't believe {inaudible} And when you start, and then you go

> on, do you know what I mean? And then you do it. Do you know what I mean? That – you don't know what you are doing, do you know what I mean? You don't know what is going to happen [...] Some people when they start xx. See me sometimes, do you know what I mean? I, I, xx. I can't control myself, miss. Like someone or something tells me, like [...] (Paul, 240-248)

To this extent, rather than - or as well as - using self-harm to gain some control over their environment, half of the men interviewed described having little or no control over their own behaviour. Having to "fight the urge to self-harm", and feeling "pushed" to self-injure, either by one's voices or by other people, were relatively recurrent themes.

Another reason why the men could not always identify *a* clear cause or trigger for their behaviour was that these were often suggested to be complex and multi-faceted (see also Rayner & Warner, 2003; Taylor, 2003a; Turp, 2002). As explained by George, "it's not one thing. It's a mix of all of them" (248). For Stephen, amongst others, this includes a combination of "background" reasons (i.e. "what we've gone through") "plus being in here" (419-420).

In addition, prisoners' reasons for self-harming were often expressed as negative emotional states (especially anger, anxiety and sadness), rather than "*concrete* events" (Snow, 2002a; emphasis added). Whilst this contributed to the difficulties in identifying *a* specific reason for self-harm, it reinforced the recurrent assertion that self-injury is more often something one does as a reaction to something and/or someone else, rather than to get a reaction from someone else (cf. staff data, see e.g. Ch. 5.3.4).

Despite the difficulties discussed above, most of the men interviewed were seemingly clear - and in considerable agreement - about the functions and meanings of their behaviour. Indeed, many seemed to define their self-harm in relation to its functions (rather, for example, than the method used or the severity of their self-inflicted injuries), which were often the very first thing to be mentioned when discussing their behaviour. In particular, and as already mentioned, self-harming was often conceptualised as a way of dealing with one's feelings and circumstances. In most cases, and contrary to the suggestions of many officers and healthcare staff, harming oneself was constructed as an *intra-personal*, rather than an *inter-personal* coping strategy.

6.1.3 "I Self-Harm to Release the Tension Sort of Thing..."[16]

Whilst prisoners' feelings and emotions had been noticeably absent in staff's accounts of self-harm, most of the men interviewed spoke of this behaviour as being (primarily) a means of escaping, expressing, and, above all, releasing their anger, sadness, stress and general "pressures". These themes were sometimes interlinked:

> I really hurt myself through emotional (.) through my emotions yeah, like how I felt, like inside yeah. (Donald, 314-315)

> I suppose as I got older I used it more for emotions, to deal with my, to deal with my emotions [...] I've used it a few times to take me away from the pressure, the pressure and stress. (um) when things get too much you know I'm used to (.) that's how I release xx. It releases (.) ..hh, it releases things on the inside of me. How I feel. And of course it gets me out of a situation, do you know what I mean? How I'm feeling. (Leo, 421-422, 174-177)

Self-harming was not only said to provide a "release" from one's feelings and emotions, but also from distressing thoughts, "pain" and flashbacks, or, in Andrew's words, one's "mental wounds". Like Leo, some found "relief" in using self-harm to "forget about what's going on" (Harold, 277) or "keep my mind occupied" (Nick, 67), whilst others described self-injury as releasing what they had "bottled up" inside, "like getting a coke bottle, shaking it, undoing it, all the pressure is going to fly to the surface" (Fred, 271-272). Others still linked their sense of relief with the sight and flow of blood, and consequent release of endorphins (for further discussion see Favazza, 1996). For Oliver, this is "the only way I can get out of my depression" (173-174):

> I cut up personally to have a bleed, to get rid of what I consider to be my blood pressure. I've been to the doctor's in the past and asked him to withdraw blood with a syringe and a needle which he has done and I've felt better. (626-628)

By bringing attention to contemporary and historical medical practices, Oliver appears to 'normalise' self-harm, whilst simultaneously de-problematising some of its effects (for an interesting discussion of the links and distinctions between "culturally sanctioned practices" and "pathological [self-harming] behaviour" see Favazza, 1996; also Babiker & Arnold, 1997). Rather than being something to be stopped at all costs, self-harming was thus not "going to do any harm [...] every now and then" (Oliver, 551-552), nor

[16] Fred, 363.

was it done "to harm myself, sort of thing" (Fred, 271). Indeed, the effects and the aftermath of self-injury were described by interviewees as overwhelmingly positive, at least in the short term. More than half the men interviewed described feeling "better", "satisfied", "settled" and "more relaxed" after self-harming, which for some explained the "addictive" nature of this behaviour, and for Oliver, Mark and Bill were a reason for not wanting to stop self-harming.

Self-harming was likened to a "safety valve", which, by "releasing the pressure out of me" (Quentin, 246), prevented one from "exploding", either at oneself, or, and perhaps more often, at others – especially officers. Therefore, this behaviour was not only said to be "not about dying" (Andrew, 273) or hurting oneself, but was also suggested to be "keeping me alive or keeping me from DOING A LIFE SENTENCE" (Ethan, 297-298). Along with four others, Donald explained:

> I never hurt myself over another prisoner [...] but with an officer like you can't touch an officer you know what I mean because for a start they will take three months off, they'll put on three months plus I've got to get (x) on my sentenced I just wanna go home as quick as possible, you know what I mean? (72-77)

For some, self-harm also "works", either to "get what I want" (Bill, 89) or to "get that little bit of buzz" (Fred, 276). However, and whilst re-conceptualising self-injury as a 'functional' behaviour may be seen to de-problematise it, it is important to note that its effects were not said to be all positive, particularly in the long term. Feeling "ashamed", "stupid" and self-conscious about "wrecking" one's body were all mentioned, together with "pain", both "physical" and "mental". Indeed, most of the men interviewed did report wanting to stop self-harming and, even those who did not, expressed regret at having ever started to do so.

6.1.4 De-Constructing 'Instrumental' and 'Manipulative' Motives: "Screaming for help" and "fighting the system"

Although most prisoners spoke primarily of the effects that their self-harm had on themselves and their emotions, other (but less dominant) themes also emerged, including the "cry for help", "attention seeking" and "manipulation" themes that had been so popular amongst staff. For instance, five of the men admitted (more or less explicitly) to

using self-harm in order to "blackmail" staff. This, however, was described as only one element of their self-injury, rather than a primary reason for it. For example, despite having been singled out by all of the staff-participants on his wing as a 'manipulative' 'attention seeker', Bill claimed to self-harm "70/30 [%] in favour of a release" (201). In addition, and contrary to what had been argued by many staff, Bill's account suggested that the severity or 'seriousness' of self-injury is not a reliable indicator of one's intentions or 'genuiness':

> Like I said like sometimes I use it to get what I want or xx swallow razor blades, I know they see it as pretty serious you know what I mean, they give me what I want. But when I'm cutting myself, it's just generally a relief of tension when I'm feeling wound up. (112-114)

Furthermore, and although most of the prisoners interviewed seemed to be aware of the negative impact of self-harm on staff, only one spoke of (also) self-harming to deliberately "disrupt" them. Also, none of the men reported self-harming to "get themselves on an ACCT" (Bernie, officer, 138; see glossary), which, indeed, was described by most as a negative experience (for a more detailed discussion see Power et al., 1997). Rather than being a spiteful and calculated "decision" (cf. staff data, see e.g. Ch. 5.2.6), self-harming was portrayed as a constricted and less than ideal 'choice', and "the *only* way to manipulate the system (4) otherwise you don't get any assistance" (George, 197-198; emphasis added). This was perhaps especially the case with regards to medication and detoxification issues. Kieran, for example, spoke of self-harming as "not manipulate people" (439), but *fighting* against a "sick" system, where "they detox you too quick" (123-124) and with the wrong sort of medication, and you have to "go and cut yourself up just to see a decent doctor" (395-396); "I don't want to die in here but at the end of the day you have to go to extremes like that [...]" (303-304).

In contrast to staff's accounts, seeking attention was not constructed as manipulative or 'medication seeking', but as an attempt to get some help and "someone to listen" (Richard, 468). Again, this was conceptualised as a desperate, but necessary act, given the inadequacies of the system, and of the "invalidating" (Linhean, 1993) environments in which the men had been raised. For example, whilst referring to himself as being "quite an attention-seeker sometimes" (757-758), Richard described his behaviour as a "desperate", though "probably silly" act, in which he engages when "I think to myself

well they're ignoring me, they're treating me like an animal, why are they doing this to me, why?" (758-760):

> Because to be truthful the way I see it, yeah? Is, I wanted them to say things that they don't mean. And when you hear that someone's injured themselves, you know, ehm, they actually speak up for them, or they'll support them. Not just against the officers, but probably against the system in terms of (.) we had a guy downstairs last week who was very very ill [...] Twice in the space of two weeks he set fire to his cell [...] And everybody was commenting on it, saying something should have been done before now, because that could be a death on our hands (L: yeah). So what is the system doing to stop this? (Ethan, 29-37)

"Crying for help" and using self-harm as a form of communication and self-expression were also constructed as "getting people to listen", "proving things" (Stephen, 499) and trying to "say I can't really take no more" (Isaac, 350-351). For Harold and Donald, "to get myself cut" is "one way of expressing how I feel" (Donald, 279), whereas Ethan and Quentin discussed how they started to self-harm "to try and let people know" about their abuse:

> I wish to now I went to the police. But I couldn't, I couldn't face them. If I went to the social services I still couldn't face them. So a lot, ehm, that's how I started self-harming like [...] saw like cuts on my arm [...] And that's when they found out (.) I'd been raped by my father. (Quentin, 218-226)

In virtually all cases, resorting to such "extreme" behaviour was not characterised as being due to one's own inadequacies or weaknesses, but "because no-one's listening to me" (Richard, 325) and/or "they don't believe me. That's why I'm saying look, have I got to hurt myself to get any help?" (Isaac, 487-488). In this context, crying for help was thus not described as passive, pathological or childish behaviour, but as an angry and desperate "scream":

> My arms, well my arms and that were just like sort of as a cry for help, I was angry, you know what I mean and I cut myself. (Richard, 430-431)

> I'm really just screaming out to see a doctor. I just want a little bit of help. With my anti-depressants and that. I can't see what way to go about it. (Tom, 112-114)

However, and whilst it may be useful to re-conceptualise self-harm as a form of communication or a "silent scream" (see Cresswell, 2005; Strong, 1998), it is important

not to lose sight of its 'message'. As highlighted by Tom, self-harming is not just about "making a point"; it is about "suffering":

> I think there could be a bit of that in it [making a point about wanting to see a doctor for medication]. But there is also, I'm, I'm suffering very bad. I'm suffering mentally, and physically. (241-242)

6.1.5 Game Playing?

Whilst self-harming was described by some as "silly" and "stupid", the reasons behind it were not. Nor was self-harm constructed as "playing games", as so often suggested by staff. Indeed, Stephen intimated that it is staff, rather than prisoners, who initiate a game of "chase":

> They just said: 'no pain, no gain!'. 'No look, it's not a game to me, this is the situation I'm in' [...] I try to explain (.) I do tell them, but it's still (.) don't wanna know. Until you do something (.) what do I have to do? Right, I'll cut myself. They might listen to me then. That's when I think to myself: 'oh, listen to xx (.) they think I'm playing games. They, they wanna play this chase – who can get who'. (668-669, 1045-1048)

For Stephen, part of this "game" had been the failure of specialist staff, and especially counsellors, to support or listen to him in a consistent way. Therefore, being ignored and not listened to were not only said to be a reason to (*have* to) self-harm to get "my point across" (621), but were also conceptualised as a "dangerous" game played by staff. In Kieran's words, "they [staff] are taking your life and they are gambling by thinking you are going to be all right" (293-294). This theme was also echoed in Tom's account. Staff's unresponsiveness to his needs was reported to have precipitated his self-harm in the first place, and, now that he still was not "getting to see someone to help me" (193), to have made him feel even more hurt and angry; "now I really do feel like hurting myself" (209).

These accounts illustrate two important points. On the one hand, they challenge many of the assumptions and (negative) stereotypes about self-harm and 'self-harmers' that had emerged from the interviews with staff, and that continue to be (re)produced in much of the relevant policy and literature (e.g. Power & Spencer, 1987; WHO, 2000). On the other hand, they suggest that negative staff reactions to repetitive self-harm do not go unnoticed amongst prisoners, nor do they constitute inconsequential "banter" (Luke, officer, 672). These points are further illustrated below.

6.1.6 Challenging Dominant Constructions of Male (Prisoner) Self-Harm

Despite some staff claiming that prisoners who self-harm "would never ever know" how they "personally" felt about them (Norma, officer, 441-446), the prisoners interviewed appeared to be very aware, and critical (although often understanding), of the ways in which staff, and particularly officers and healthcare staff, (mis)construed their self-harming behaviours. Indeed, the ways in which many prisoner interviewees seemed to position themselves, and their self-harm, appeared to reflect and challenge many of the negative stereotypes emerging from the interviews with staff. This included presenting oneself as a "human being", a "victim", and, above all, an "honest" and "truthful" person. Moreover, prisoners often appeared to define their self-harm by what it was *not* (e.g. "attention seeking", "crying for help", "playing games" or "superficial scratches"), seeming to assert the "seriousness" and "reality" of their self-injury, and of the reasons behind it.

The men's constructions of their own and - to a lesser extent - other prisoners' self-harm, also challenged many of the assumptions made by staff (particularly officers and healthcare staff) in relation to the causes, functions and meanings of self-harm, and with regards to the type of support wanted, and needed, by prisoners who repeatedly self-injure. Furthermore, and contrary to what had been proposed by many staff, this behaviour was said to be both preventable and 'stoppable'. Although this was not necessarily a priority or *the* priority for all of the men interviewed, six participants discussed stopping as a clear possibility, despite some difficulties and "relapses" (for a recent - and rare - discussion of resolution of self-harm see Sinclair & Green, 2005).

Also, staff's rigid categorisations of self-harmers into different types (see Ch. 5.1.1) was contrasted by the recurrent claim that self-harm serves multiple and shifting functions:

> There's all sorts of things. There's blackmail issues, there's also a real need, there is also a real craving, there's also a real release, there's also this aspect – do you know, I mean. And also, it's quite addictive – out of the trauma or whatever the reason is, there is ahh ..hh. You know, it's quite frightening you get ..hh, you know, Jesus, what's happened, xxxx {inaudible} you know, xx release from that {inaudible} (Andrew, 428-432)

Notably, a few of the men interviewed also spoke of there being different types of self-harmers, most conspicuously: those (normally "others") who "might cut up just for the

sympathy" (Oliver, 489) or "because they want to kill themselves" (Fred, 362), those who "self-harm to release the tension" (Fred, 363), and "a couple of people who are bastards" (Andrew, 55) and "are playing the ticket just to get this and get that" (Isaac, 399), rather than being "genuinely, well, need help" (Isaac, 400). However, these categories were *not* constructed as being mutually exclusive, nor were the circumstances, methods or severity of one's self-inflicted injuries said to be static. For example, most of those who described themselves as *not* being suicidal had *also* attempted to take their own lives in the past and/or declared to be "ambivalent" or indifferent about living or dying at the time of their self-harm:

> I know it sounds weird for a self-harmer to be like so worried about dying but, like, it's not about dying, I committed – I took lots of overdoses and meant to die actually, yet I took some just attention seeking. It's a really weird thing. (Andrew, 272-275)

Whilst self-harm and suicide may well be different behaviours (Favazza, 1998; HMCIP, 1999; Spandler & Warner, 2007), 'self-harmers' and 'suicidals' are *not* "two completely different things", as many staff had suggested (see e.g. Ch. 5.2.1; for further discussion see Hawton & Catalâan, 1987; Liebling, 1992; Williams, 1997). To assume so may be both misleading and potentially dangerous (Dear, Thomson, & Hills, 2000).

Another distinction that the prisoners failed to make was that between "one-off" and "prolific self-harmers". Some did allude to the frequency of their self-harm (often having been prompted to do so by the researcher), and a few referred to it as a "habit", an "addiction" or something they had "always done". However, the repeatedness of one's behaviour did not appear to be a significant factor or recurrent theme. Whilst many staff seemed to believe that all self-harmers are 'non-suicidal', the prisoners themselves appeared to suggest that all or most self-harm is repetitive (which indeed is consistent with previous studies; see e.g. Favazza & Conterio, 1989; Hawton et al., 2006).

Also resisted in the accounts of prisoners was healthcare staff's suggestion of a rigid inside versus outside (prison) dichotomy. All but four of the men interviewed had also self-harmed outside prison, and in most cases had started to do so at a young age (see also Karp et al., 1991; Livingstone, 1997). However, because of factors inherent to incarceration (including one's relationships with staff and the reduced availability of

alternative coping strategies), many indicated that they mainly or only self-harmed in prison. This, in turn, raises questions about (some) specialists' conceptualisation of self-injury as being *only* due to "deep issues" from the men's "past".

Prisoners' constructions of their own self-harm also challenged some of the assumptions that are often made about male self-harm, and male *prisoner* self-harm, as well as some of the findings of previous studies in this area. For example, male self-harm (in general) has been discussed to be more violent than that of women, and assumed to be characterised by "greater suicidal intent, aggression [...] and less concern about bodily disfigurement" (Hawton, 2000, p. 484). However, and despite a couple of the men conceptualising their self-harm as "violence" and emphasising its 'physicality' and 'destructiveness' (Ethan, 214), many interviewees spoke of their *not* being suicidal and expressed shame, hatred and guilt over their scarred bodies. Indeed, for five participants this was a main reason (or *the* main reason) for regretting having ever started to self-harm, and for wanting to stop.

In addition, the 20 men interviewed did *not* construct their self-harm as being (mainly) "manipulative" (WHO, 2000), "instrumental" (Power & Spencer, 1987; Snow, 2002a), or "motivated by concrete events" (*Ibid.*), nor as an attempt to "signal strength" (Rivlin, 2006). On the contrary, self-harming was predominantly conceptualised as signalling "weakness", and to this extent was described as "stupid", "childish" and, above all, "embarrassing" (see also Taylor, 2003a). However, rather than explicitly constructing self-harm as a female activity – as one may expect, given the popular "feminisation" (Brickman, 2004; Shaw, 2002) of this behaviour (which was indeed reflected in the accounts of some of the staff interviewed) – any comparison or reference to women's self-harm was noticeably absent in all cases but one. Being, and in some cases having spent much of their lives, in (almost) all male - and "macho" - environments, these men seemed more accustomed to, and preoccupied with, comparing themselves to other men, rather than women. The issue was not whether one was a 'man' (cf. Taylor, 2003a), but rather what *type(s)* of "grown man", or version(s) of masculinity, one was able to "perform", and how this was (re)produced, negotiated and resisted (see also Elliott, n.d.).

In many ways, the men's failure to construct their behaviour as distinctly male (rather than female) may seem legitimate and appropriate given that participants drew on many of the themes and discourses that have been identified in the literature on non-suicidal self-injury amongst women, both in prisons (e.g. Howard League, 2001; Snow, 2002a) and outside (see e.g. Chantler et al., 2001; Harris, 2000; Spandler & Warner, 2007; Strong, 1998). Arguably, what is more inappropriate is the tendency to *assume* that men are more likely to self-harm for manipulative motives and "minor issues", and for them to be almost automatically excluded from the (perhaps more sympathetic) 'victim/survivor' discourses and systemic frameworks that are becoming gradually more accepted in relation to women's self-harm, and women's imprisonment. To construct one's analysis in terms of power and power relations, and using a social constructionist view of gender, is arguably a more productive approach than to focus on unitary and stereotypical notions of woman and man (see also Marzano, 2007).

6.2 Prisoners' Experiences of Staff's Reactions to Their Self-Harm

The findings presented in the first part of this chapter lend support to "combined [importation and deprivation] models" (Liebling, Durie, et al., 2005) of prisoners' distress (see also Ch. 1.3.3 – 1.3.5). Whilst the latter have been predominantly discussed in relation to suicide (rather than non-suicidal self-harm) in custody (see Camilleri et al., 1999; Liebling, 1995), the notion that "prisons expose already vulnerable populations to additional risk" (Liebling, Durie, et al., 2005, pp. 209-210) is clearly also relevant to the issue of non-suicidal self-injury.

Particularly in view of the difficult backgrounds and life histories of the men interviewed, it would be inappropriate to suggest that prisons *cause* self-harm, or that any single prison-related factor may be inevitably associated with the risk of prisoners injuring themselves. On the other hand, these accounts do suggest that "suicidal [and self-harming] behaviour is not just a function of individuals' vulnerability and circumstances, but it is also influenced by the quality of prison regimes and the response of staff" (Home Office, 1999, para. 7.2).

As noted by Liebling and Maruna (2005, p. 212), there are "hints" in the literature on (suicidal) self-harm in custody and the effects of imprisonment about "the importance of

the psychological [prison] environment [... and] the manner of one's treatment [...] but these ideas have rarely been empirically tested". Despite growing recognition of the crucial implications of staff's relationships with, and attitudes towards prisoners who self-harm (see Ch. 1.6), to date there have been no participant-centred accounts of prisoners' experiences of these. Nor have prisoners' views specifically been explored regarding the potential impact of staff's reactions to their non-suicidal self-harming behaviour (however, for a discussion of prisoners' perceptions of their relationships with staff see Liebling, 1992; Rivlin, 2006). These questions therefore became a central part of the prisoner interviews (see also Ch. 4.9).

As reported by previous (non-prison based) studies (e.g. Arnold, 1995; McAllister et al., 2002; Pembroke, 1991, 1998), the men's experiences of staff's responses - to them and to their self-harm - were generally rather negative. There were, however, some variations in how different staff groups were reported to react to self-injury, and how the men *expected* them to respond. For this reason, data are presented in relation to each separate staff grouping before more generalised conclusions.

6.2.1 Specialists' Responses to Repetitive Self-Harm

Unfortunately, due to the heterogeneity of this group, it was unfeasible to ask participants about the responses of all specialist staff. However, when they were mentioned, specialists tended to be portrayed in positive terms. This was especially the case in relation to psychologists, counsellors and members of the chaplaincy. For instance, four of the men interviewed reported positive experiences of counselling and two spoke very enthusiastically of a weekly "self-harm group" run by psychologists. The staff member responsible for this group was singled out by Ethan as having helped him when "he was a total wreck" and was spending "quite vast periods of time" in a "[suicide] supervision cell" (6-7). In his account, it was "she [who] got me all the, the help and support and suddenly I built myself up" (14-15).

Nevertheless, these feelings were not shared by all of the men interviewed, nor were counselling or group therapy necessarily what everyone wanted or felt would 'work' for them. For instance, Stephen spoke of his disappointment when his counsellor "disappeared" after 6 sessions, whereas George and Harold described having been

"dropped" from the self-harm group, without knowing why. Some prisoners also seemed to be unaware of in-reach teams, and rarely (if ever) spoke of their interactions with them, governors, nor the suicide prevention co-ordinator. Even though most of their work may take place 'behind the scenes', the lack of data in relation to what ought to be central figures in suicide and self-harm prevention (see HM Prison Service, 2003, 2005a) is arguably concerning, especially given that the men were specifically asked what support was available to them in the prison.

6.2.2 Officers' Responses to Repetitive Self-Harm

Officers' reactions to self-harm were predominantly described as negative. Particularly recurrent themes were that (with some rare exceptions) officers did not care, understand, or care to understand about self-harm or self-harmers, or indeed prisoners in general. For instance, Leo argued that most officers, especially male officers, "don't know the reasons" and "don't ask for the reasons" (257-258), and, as result, "they just sort of look at you as weak" (237). Being treated "like a kid" and "called stupid", and assumed to pose a risk to others, were also mentioned, though not quite as often as being laughed at and told to "do it properly". According to Paul, "some of them they want you to kill yourself" (195-196).

In many cases this was said to be more than just "banter". Officers' unsympathetic attitudes and failure to "take it seriously" (Nick, 418) appeared to be reflected in various negligent, "dangerous", and even "brutal" practices. Ethan described some officers as being "very abrupt" (71), Isaac recalled an episode when they had "forgotten" to send him a "listener" (see glossary), whilst Donald implied that they deliberately "won't come straightaway" (499) when he self-harms. Also, referring to when he was held in the segregation unit, he reported that they:

> Wouldn't search properly yeah and I'd have a razor blade on me and I was hurting myself down there and they would hit me for that [...] I mean, the pain they've put me through, you know what I mean just for like (2) just for hurting myself yeah? Like they would hurt me two times more like in a way that they would put me on the floor and put me in all kinds of (.) like my arms like that in the air and with locks and all that. (123-124, 542-545)

Whilst Quentin accused most officers of "doing nothing" and "letting you just carry on [self-harming]" (457), others described officers as going through the motions of "cutting

you down", "taking me to the nurse", "watching you" and "putting you on an ACCT" (with the latter two often used as being practically synonymous). For the most part, however, this was said to be done without talking or listening to them, asking them why they had done it or showing any signs of "care". Tom, for example, described "getting no help whatsoever"; "they bring me downstairs. They bandage me up and they put me back in my cell" (281-282).

Nevertheless, comments about officers' reactions to self-harm were not all negative, nor were *all* officers said to respond in unhelpful ways. Whilst Paul and Quentin seemed to be rather ambivalent about the reactions of staff, five others pointed out that officers' responses were not homogenous, with some (though often described as a minority) being "OK". Moreover, Ethan and Fred described noticeable improvements in the "mentality" and reactions of staff and, along with Andrew and Mark, implied that most officers *want* to help, but can't.

6.2.3 Healthcare Staff's Responses to Repetitive Self-Harm

The reactions of nurses and doctors were also portrayed as mixed, but mainly negative, in some cases even more so than those of officers. Indeed, only five prisoners made positive comments about some or all of the healthcare staff. The majority of the men interviewed accused them of not "caring", and of responding in unsympathetic, "very rude" and "judgemental" ways. This included calling those who self-harm "everything under the sun" (Andrew, 345-346), patronising them and assuming that they are "playing with them" and/or "seeking attention". In Nick's words:

> In here they don't see it as serious. They think you might be playing with them; you are playing tricks on their mind or something [...] to draw attention; to make them do something. Do you know what I mean? They don't see like what is in your mind, or what you think. (394-399)

Being accused of "wasting" staff time and being "hated for it" were also reported, as well as being told to "do it properly" or shown how to do so. Once again, staff's apparent "anger" and "annoyance" at prisoners' self-harm was said to be more than a "really bad attitude", and was associated with a range of unprofessional and negligent practices. In some instances, nurses and doctor were said to "just patch you up" (Tom, 128) or "just offer you medication", but "don't believe you" and "can't even give you a

chance to talk with them" (Harold, 235). For others, nurses would not "even turn round to call the doctor out" (George, 289), and would refuse to give medication and/or to bandage their self-inflicted wounds. To this extent, medical staff were said to be "worse than officers", which some implied "is the wrong way round really" (Andrew, 393) - a) because "they [doctors and nurses] are supposed to be trained", but "they obviously don't understand" (*Ibid.*, 371-372) and b) because "they've *got* to care for you" (Quentin, 478; emphasis added), but they don't (some of these implications of this discourse for healthcare staff are discussed in Ch. 7.1.3 and 7.4). In Leo's words:

> Nurses are supposed to care [...] they are supposed to have the responsibility of care. They don't show that. You know, they don't like, they are not like, they are not what you expect a nurse to be. You know, to help you with your, your problems. They are completely the opposite. And they, they'll make fun of you, you know. Patronise you (2) while they are stitching you up. It's sick. (383-388)

In describing the responses of nurses and doctors, some of the men interviewed appeared to draw on an inside versus outside (prison) dichotomy, which, in many ways, reflected the one so often invoked by healthcare staff when discussing prisoners who self-harm (see Ch. 5.3.1). Contrary to the findings of community-based studies on workers' attitudes to self-harm (see Ch. 3), "outside" was said to be "different", in that there staff "see it seriously" (Nick, 394) and "care about people" (Richard, 632). For this reason and for various difficulties and delays in seeing a doctor and/or obtaining medication, eight participants explicitly contested the very notion (now supposedly a *requirement)* that prisons offer a level of 'care' "equivalent" to that available outside (see HM Prison Service & NHS Executive, 1999; Home Office, 1991; Rickford & Edgar, 2005; Wilson, 2004):

> They are the lowest form of life ever. The nurses and doctors really do not give a FLYING MONKEYS, I'm trying not to swear now. It is the worst possible care they could give, they do not GIVE A TOSS [...] They just don't wanna do anything, they're better than me, that's it. That's the way they look at it, they are better than you. You're supposed to get NHS care, you don't even get that, it takes up to a month to see a doctor and when you do see a doctor they sit there, they don't examine ya, they ask you what's wrong, if I knew what was wrong I wouldn't go and see the doctor would I! (Fred, 592-600)

Like Fred, Isaac and Jack also suggested that healthcare staff's negative reactions and practices were not necessarily related to their being 'self-harmers', but rather to their

"painting everyone with the same brush" (Isaac, 405), as "criminals", "junkies" (*Ibid.*, 421) or both.

6.2.4 How Do Staff's Reactions Affect Prisoners?

Not surprisingly, most prisoners described being affected in negative ways by staff's reactions to their self-harm. Indeed, Bill was the only interviewee to claim that "it don't phase me really" (135). Most others spoke of feeling "hurt", "angry", "small" and "like an oddball". In turn, this was said to have two main (and possibly interlinked) effects. Firstly, "that just makes you just sort of close up" (Leo, 244); secondly, "it can make the situation worse" (Ethan, 361-362):

> It's kind of weird, because you do it for attention, but you get all the wrong kind of attention back. All (.) hurt ..hh, xxx. Do you know what I mean? They make you feel like a piece of scum. It doesn't really, it just reinforces the negativity you already feel anyway. (Andrew, 374-377)

For Leo and Nick, being "ignored" and/or "not taken seriously" by staff in relation to self-harm could lead to further and more severe self-injury. On a more general level, six others implied that "the way they are treating me" and/or "failing to get me any help" (including medication) were a cause or *the* cause for their self-harm. According to Isaac, "it's like being bullied all over again" (392), whilst others spoke of feeling "taunted", "tormented", "persecuted", "teased", "brushed off", and "pushed to self-harm" by staff, particularly officers.

Harold and George, however, suggested that this was not a simple cause and effect relationship:

> Obviously you are going to get hurt (2) that you feel like prison officers are wishing you to do something. But (3) not make you do it. If you do it and then they are going to feel they win. (Harold, 195-197)

Drawing on a similar theme, George claimed that this had been the very reason he had stopped self-harming. Given that much of his self-injury was "to stop me doing it to someone else" (166), often a member of staff, he eventually decided "I'm not going to [...] harm myself anymore for these people [...] I just don't do it anymore. I won't hurt myself for the sakes of them. For the likes of them" (190, 194, 209-210). As a result of stopping, however, he reported feeling "a lot more stressed now. I find myself, ehm, a

lot more harder to live with it. With my cell mates and that. Ehm, something little, even if something little goes wrong, I just ah – row and scream and shout and (..) x. x bring depression out" (267-269).

6.2.5 Prisoners' Preferred Staff Reactions

There were also some differences in the reactions the men wanted from staff in general. The majority of those interviewed declared wanting and, in some cases, *needing*, more "support", "respect", "care", and perhaps above all, "understanding" - both in relation to the meaning(s) of their self-harm and, more generally, to mental health issues. Wanting to be taken "seriously" and treated like "adults" were also mentioned, together with people "jumping onto it [self-harm] more" and "good communication". Being able to trust, talk and being listened to by staff who are "nice and polite" were said to help prisoners feel more "comfortable" and less "uptight":

> A good officer is er an officer that um says hello to you in the morning and xx, an officer who asks if you're feeling okay [...] like that just cared, that just showed a bit of um compassion or something like that, that would really like build on my self-esteem sort of side you know, like that I know there's someone who does care about me and it don't have to be someone who I have to befriend or I have to give something to or anything like that, it's just someone from the goodness of their heart who's come along and said 'Look are you okay today?'; 'how are you feeling today?' and all of that. 'If there's a time of the day you're not feeling okay, then talk to me, talk to me' you know. Like I've got enough inmates who are like that, if some of the officers were the same, then they would be the perfect officer. (Donald, 550-562)

However, 'good' relationships, staff being "polite" and "jumping onto [self-harm]" were not inevitably constructed as a sign of "care". Furthermore, being "friendly" and "sympathetic" were not necessarily what all of the men wanted or expected from staff, particularly officers. Indeed, a few participants appeared to be indifferent or ambivalent about staff's reactions to their self-harming behaviour, especially in relation to their showing "sympathy and compassion". Andrew, for example, cast doubt on the very notion of there being a "useful" way to respond to those who self-harm, because "I don't think you can stop someone self-harming until they are ready to stop" (293-294). Moreover, and despite describing "sympathy" as the reaction one would "obviously" want, Andrew questioned whether a hostile response could be "a good lesson I don't know" (291); "I think the most sympathy you get through self-harm, the more you do it"

(330). Ethan also argued that, whilst not wanting them to "shout" at him, "I don't think I would like them to sort of (.) ehm, pat me on the back and say 'good boy', you know?" (354-355).

Responding to self-harm with "compassion" was not only said to be potentially counterproductive, but also insufficient and/or ineffective. It was apparent that some of the men interviewed wanted "action", rather than "sympathy". For instance, Stephen implied that being able to talk to someone is not necessarily helpful, unless that member of staff has the "power" to "assist me". Similarly, according to Kieran:

> It's not sympathy you need you know, when you think you need help. It's all very well everyone being sympathetic towards you but it's the help you need, you need action don't you, know what I mean? (318-321)

In addition, whist many wanted staff to be more understanding and respectful, this was not necessarily the main help or support they felt they needed. For example, whilst Ethan recommended a personal officer scheme (see glossary) for those at risk of self-harm, and Jack suggested for at least some officers to "have more training on people that suffer from mental illness like myself and others" (181), five others mentioned wanting help with issues around drugs and medication, and three expressed a need for more distractions, including being able to work and having more time out of cell. Moreover, some of the men wished to have more opportunities to talk with other prisoners, rather than staff, and highlighted their important role in relation to suicide prevention (for further discussion see Snow, 2002b).

However, not wanting or prioritising staff sympathy is not the same as wishing them to be *un*sympathetic. Whilst improving staff-prisoner relationships may not be sufficient to address the complex needs of those who harm themselves in custody, more 'concrete' help and interventions may themselves be ineffective in the context of an unsupportive culture. As argued by Jack:

> They need to have a lot more help for the mental health. A lot more help. And a lot more screws[17] in here with a lot more understanding. And the GPs need to listen a bit more and not tar everybody with the same brush as being a junkie. Because it's all right sending me to yoga, but yoga ain't worth a wank (3) it does not relax you at all. For someone like me – don't get me

[17] In prison slang, term used to denote officers.

> wrong I've done it twice, and it did relax me for that hour – and as soon as I walked back on the wing (.) and got spoken to like a piece of dirt (.), do you know what I mean? My back went ..hh up again. And then starts off again. (153-159)

6.2.6 Is it Possible for Staff to Be 'Caring'?

For some of the men interviewed the question was not necessarily whether it might be beneficial for staff to be "caring" and "sympathetic", but whether this was indeed feasible. Firstly, a few prisoners described an "us and them" split, whereby "cons[18] look after cons and screws look after screws" (Fred, 112-113). For Oliver and Bill, this divide, and the very nature of the role of staff (i.e. their "keeping me in here"), also meant that "I don't want to get on with them" (Oliver, 139-140); "I wouldn't talk to 'em [...] They're screws and we're inmates" (Bill, 173-175).

In contrast, others focused on staff's inability (or reduced ability) to be "helpful" and "supportive", mainly because of a) the "messed up system" in which they worked (Jack, 109), and b) the effects of self-harm on staff themselves. Both of these points, which were at times interrelated, also imply that staff may not necessarily be to blame for their negative responses to self-harm. Whilst some prisoners had accused staff of not *wanting* to help or support them, seven interviewees - including a few who had criticised staff's attitudes and behaviours - argued that negative reactions may be "understandable", and "not their fault" (Jack, 225). In Kieran's words, some prisoners could "see their point of view as well" (414), particularly, it seemed, in relation to officers, rather than healthcare staff.

A recurrent theme was that staff are not "geared" to deal with self-harm, or indeed issues around drugs and mental health. Andrew, for example, suggested that they lack the "manpower" or "time" to show "sympathy and compassion and all of that lot" (306) or, in Ethan's words, to "cope with me [...] guard me 24/7" (137-138). In Mark's case there was the additional issue that staff could not speak his language, and thus address many of his needs. George, Jack and Andrew also highlighted the lack of relevant training available to prison officers:

[18] In prison slang, term used to denote prisoners.

> But it's here, it's this place, like, they don't understand. It's not really them, it's just they don't, they don't get enough training [...] but it's not their fault. They've got to start learning, you know? (Jack, 139-140, 225-226)

According to Fred, all of these difficulties are further compounded by a managerial culture that has created too many, and often conflicting rules about managing "risk":

> So their hands are tied. One minute they say oh okay you are at risk, we'll put you in a safe cell but the regulations say he's at risk, he can't go in a cell on his own. So the prison can't win at the end of the day and they're trying to help people but there's so many rules and regulations to say what they can and can't do, it's just backfiring. (304-308)

In addition, the "macho thing" amongst male officers was said to be such that "where female officers they sort of mother you [...] The blokes are more: 'oh hang on a little bit, I can't get too friendly'" (Fred, 552-555).

In this "stressful environment", the pressures of staff were said to "show" in negative reactions, particularly as dealing with self-harm was suggested to "make their life harder" (Leo, 288):

> So, yeah, sometimes officers get under stress in here; sometimes they do show that. Sometimes they do react to you. And sometimes, some of them can (.) be very abrupt [...] No one could ever condemn them because they are in a stressful environment, and when you are dealing with – and this is not (2) x, a game against the guys who are in here, but everybody is wanting things (.) in prison [...] Not understanding there's 280 people on this wing. And there's what – 6 officers? Trying to cope with these, how many people. (Ethan, 69-71, 58-64)

> It affects them because they have to write up suici-you know, ACCTs; they've got to take ACCTs x; they've got to watch you. It makes their life harder. That's probably why x as well. That's why they've got that attitude towards. (Leo, 287-289)

Only three men appeared to deny that self-harm may have a negative impact on staff themselves, with one more arguing that he did not care either way. At least half of all participants acknowledged the effects of their behaviour on staff, both professionally and, but to a lesser extent, on a personal level. A particularly recurrent theme was that self-harm created more work and paperwork, "causing them a lot of like time, time that they ain't really got" (Donald, 67-68). For this very reason, their behaviour was said to be viewed by staff as "annoying" and "inconvenient". This was perhaps especially the

case as "they don't like being blackmailed. And a lot of self-harmers do blackmail" (Andrew, 399), and because they "must put up with it all the time" (Isaac, 401) and thus "probably get sick of it" (Leo, 399). In addition, three interviewees spoke of self-harm as being "traumatising", making staff "freak out" and "panic", and posing a potential threat to their health, as "one splash of blood in the eye, anything like that, and they can catch all sorts of things" (Andrew, 315-318).

6.3 Conclusions

The findings from the interviews with prisoners suggest that the men's constructions of self-harm (particularly in relation to their *own* behaviour) draw on a variety of themes and discourses that (re)position them as 'victims' and/or 'survivors' of their lives, their emotions and the system of which they are captive. In so doing, the men interviewed challenged and resisted many of the negative stereotypes around male self-harm and male prisoner self-harm that had been dominant in the accounts of staff, as well as in the (scant) literature on this topic.

Staff's constructions of self-injury were not only said to be inaccurate and misinformed, but also to be far from inconsequential. Indeed, staff's responses were implied to have real, material implications for the men concerned, not least for their self-injurious behaviours. The data suggest that the effects of "sympathetic" and hostile staff reactions are neither simple nor fixed, and are perhaps attenuated by (some) men trying to understand and justify the attitudes and behaviours of staff (possibly more so than staff themselves appeared to do in relation to the prisoners' self-harm). In turn, these rationalisations appear to shift attention - and blame - away from individual staff members, and onto self-harm itself as a "difficult" and recurrent behaviour and, even more so, on the inadequacies of the wider system. This simultaneously reinforces a theme that ran throughout the interviews with the prisoners: it is not the 'self-harmers' who are 'inadequate' or 'poor copers', but rather it is the broader system that is "sick" and cannot deal with self-harm (see also Smith, 2000; Thomas et al., 2006).

Although Kieran suggested that staff "won't admit" to feeling affected by or "caring" about self-harm, these findings imply that in order to understand - and potentially address - staff's reactions to this issue, it is important to explore its potential effects on

staff themselves. Moreover, data suggest that these need to be located within the wider context and content of their work, and discussed in relation to the cultural and organisational resources (or lack of) available to staff in dealing with repetitive self-harm. It is to these that the following chapter now turns.

Chapter 7. Dealing with Repetitive, Non-Suicidal Self-Harm: Staff's experiences, reactions and concerns.

The data presented in Chapters 5 and 6 are consistent with previous studies in suggesting "the value of supportive attitudes in staff, the distress caused by negative attitudes, and the wide variability of staff attitudes in general" (Medlicott et al., 2004, p. 10). However, the question of what may underlie or explain these mixed – but predominantly negative – responses has received little attention in the literature, particularly in relation to repetitive, non-suicidal forms of self-harm. In order to address these questions, it is useful to consider staff's accounts of their experiences and concerns in dealing with repetitive, non-suicidal self-harm. As argued in Chapter 3 (see especially Ch. 3.1), focusing on the views of those who self-harm can highlight, in very powerful ways, the detrimental impact of negative staff attitudes. However, it may provide limited information as to why staff may respond to self-harm in such ways, how *they* may be affected by this issue, and what, if anything, could be done to reduce or prevent these reactions. Considering staff's views as to what may cause these responses, as well as their possible functions and implications for staff themselves, may help to further contextualise, deconstruct and potentially challenge negative staff reactions to self-harm and 'self-harmers'.

This chapter reports the main themes from the interviews with the 38 staff participants, on their experiences of working with repetitive, non-suicidal prisoner self-injury. In view of some remarkable parallels and similarities, the accounts of officers and healthcare staff are presented together. As these are (also) located within the context of their work, issues that may have been specific to either of these groups are also highlighted. Regrettably, there was insufficient data to warrant a separate discussion of specialists' main issues and concerns in dealing with self-harm (see Ch. 9.5.1). Nevertheless, the accounts of specialists are incorporated in the second part of the chapter, which reports staff's views as to how they (and others) cope with this aspect of their work. Following comments from both prisoners and staff that negative and "blasé" attitudes may be a way of dealing with the difficulties and uncertainties of their work with self-harmers, the chapter considers how these very responses may serve (or not) to protect staff from some of these pressures. In other words, whilst previous chapters have

focused on how staff's constructions of self-injury may impact on prisoners, some of their implications for staff themselves are here considered. The chapter concludes with some reflections on the desirability and feasibility of alternative, and more positive, staff reactions to self-harm.

7.1 Officers' and Healthcare Staff's Experiences and "Frustrations" in Dealing with Repetitive "Self-Harmers"

As anticipated by prisoners, and consistently with the literature reviewed in Chapters 3 and 4, the vast majority of participants described their experience of working with prisoners who repeatedly self-harm as "challenging", "draining", "stressful" and, above all, "frustrating", at times "infuriatingly" so. These themes were drawn upon by all of the 30 officers and healthcare staff interviewed, with the only exception of Jane (healthcare staff) and Ian (officer) (who, however, commented that prisoners "using" repetitive self-harm as a "bargaining tool [...] are a pain in the arse" (146-150)). In Ed's account, to become frustrated was constructed, and normalised, as being "obvious":

> My experience of working it's quite frustrating obviously. It's a very frustrating experience, because you (.) I find that ehm ..hh there is not, there is not a great deal of (3) ehm, I just think ..hh (2) I would like to approach it differently. I don't know where, which way I'd like to go with them; but the way we are going no:ow is not working, because of, constantly repeating it. You know. Self-harm. So either we are doing it and we are not doing it right. I'd like to go somewhere else with it, but, ehm, I don't think this is the place to do it. I don't think prison [...] it's not, ehm, not, not anything really that could be done in a prison. (Ed, healthcare staff, 119-124, 103)

Ed's words highlight three important and recurrent themes. Firstly, that the repeatedness of "constant" self-harm may be an important factor in staff's reactions to and experiences of this issue (see also Pannell et al., 2003). Secondly, that part of the frustration staff described in dealing with this behaviour may be associated with feelings of helplessness (see also Deiter & Perlman, 1998; Rayner et al., 2005) and low "job control" (Karasek, 1979), both in relation to not being able to decide how to "approach" those "constantly repeating it", and in relation to successfully helping them and/or stopping them from self-harming. Thirdly, that some of these difficulties and frustrations are - in part - resolved by resisting one's role with prisoners who self-harm, and shifting

responsibility onto other agencies, or other staff groups. Whilst the latter theme is discussed later in the chapter, the former two points are further illustrated below.

7.1.1 Why is Dealing with Repetitive Self-Harm and Self-Harmers "Frustrating" for Prison Staff?

Particularly in prisons, much of the literature on self-harm, and on staff's views and concerns in relation to self-injury, have focused around issues of suicidality and 'seriousness' (see Ch. 1). Similarly, most studies on stress and trauma in the workplace have been biased towards one-off "head-line friendly" events (Rick et al., 2002), overlooking the potential effects of more 'routine' stressors, i.e. ongoing, yet lower level incidents. Arguably, given that most staff constructed prisoner self-harm as being predominantly non-suicidal (see Ch. 5), it is difficult to establish whether or how their views of repetitive self-harm may be (negatively) influenced by this behaviour being repetitive, as opposed to being non-suicidal. Nevertheless, their accounts suggest that the frequency or repetition of self-harm is (also) an important dimension for understanding the possible impact of this behaviour on staff – on a number of (often interrelated) levels.

7.1.2 "Draining" and Abusing (Poor) Resources

Particularly in officers' accounts, one of the worst aspects of dealing with repetitive self-harm was the effect this had on their already poor and "stretched" resources. For many, being seriously "short-staffed", and having "100 other things to do", meant that this area of work was not only potentially "exhausting", but ended up "taking up a lot of time that could be on other people" (Harry, officer, 257), including those who had "real problems":

> When you get someone self-harming, continuously, it just (.) it just messes up the whole regime. And then makes your job so much harder. (Norma, officer, 620-621)

Eight interviewees spoke of being short-staffed as one of the worst aspects of dealing with this area of work, whereas three others expressed their frustration at "the people at the top", whom they described as being only interested in statistics and cutting down costs:

> The problem is the prisons are run on as little money as possible. They've cut the budget, and that's it. No matter how much the big boys at the top talk (.) about rehabilitation, and getting them off drugs, and this, that and the other. When it comes down to here it is completely lo:ost, because you haven't got the staff. And you haven't got the money to do it. And it's a shame, because you could do so much. (Harry, officer, 124-129)

> Nowadays you've got all the people at the top saying: 'we are doing this for prisoners. We are doing that for prisoners', but they actually, they are actually doing nothing. Because they don't cost a prisoner's life. Because if they, if they really thought what they are telling us they thought about prisoners, they'd put more staff in the job. (Luke, officer, 268-272)

Thus, staff were not (only) frustrated because of "repeated self-harmers" taking up so much of their time, but - in seven cases - also because they felt that with more time, staff and resources they "could do so much more" in relation to self-harm. For Ann, Jane and Nathan, being unable to "have quality time with the prisoners" (Ann, officer, 309) was not only detrimental to the prisoners themselves, but also meant that "there is no (1) quality in an officer's job anymore, or satisfaction" (*Ibid.*, 322). Furthermore, not being able to "deliver because they haven't got the staff" was said to be creating "friction between staff and prisoners" (Luke, officer, 548-549).

Matthew, however, implied that this may be an "excuse":

> They don't mean it. If I'm honest. They probably don't mean that. They can find time. If they want to find time, they'll find time. A lot of people can't stand talking to them because they are whinging and whining, all the time. That's why people can't find time for them. Because you know that as soon as you do, they are like 'do this for me. Do that for me (.) {in a whiney voice} uh, uh, uh (.)'. And they'll take up all, a lot of their time. (Matthew, officer, 365-369)

When the prisoner concerned was thought to be self-harming "just for attention" (as opposed to being a "real self-harmer"), the issue was not necessarily (or exclusively) that staff did not have the time to deal with him, but also that this was seen as "wasted" time, and therefore particularly frustrating, as well as less likely to make staff "feel sorry for them". The effects of dealing with this issue were thus not only discussed in relation to the behaviour itself, but also to the type(s) of prisoners said to engage in it.

Once again, the emphasis seemed to shift from self-harm to 'self-harmers' (see Ch. 5.1.1), with "prolific self-harmers" being described as difficult, draining and frustrating to work with – almost regardless of their actual self-harm. Reflecting many of the assumptions made about their intentions and dispositions (see Ch. 5), they were often described as "verbally aggressive", "unpredictable" and "very abusive", both of staff and of the (ACCT) system they were said to be using to manipulate staff. To this extent, six officers and seven medics appeared to position themselves as 'victims' of their "threats" and behaviour, and described their risk and fear of being "held at ransom", "conned", "controlled" or even "attacked". In turn, this was said to leave staff feeling "annoyed", as well as "a bit sort of sceptical of whether or not someone's doing it for the right reasons" (Norma, officer, 433-434):

> They know they've got us over a barrel. 'If you don't do that then I'll, I'll cut myself'. That annoys me. Because that's, that's a blackmail. They are blackmailing into doing things like that. I say: 'that's your choice, if that's what you want to do'. (Olivia, officer, 427-427)

7.1.3 Having *to Care for Prisoners Repeatedly Harming Themselves*

In this context, having to care for prisoners who repeatedly self-harm was, in itself, constructed as a source of tension and frustration. For instance, whilst eight officers seemed to resist the very notion that they might have the time or training to fulfil a 'caring' role, their having to, nonetheless, "care" for prisoners who self-harm was sometimes portrayed as problematic and counterproductive, particularly in relation to certain types of 'self-harmers'. For these reasons, officers' frustrations were only directed at prisoners themselves, but also at the current system of suicide and self-harm prevention. With its "defensive" (Inch et al., 1995) and "gentle" approach (Luke, officer, 619), this was described by some as being often "wasted" on "attention seekers", whilst "probably missing out on the real people" (Matthew, officer, 276). In so doing, it had therefore contributed to creating both (repetitive) "attention seekers", and "suicidal" prisoners:

> There was certainly a lot less, ehm, self-harm, when I started. I mean, it happened, it always happened, but, ehm, to a certain extent it was treated slightly more robustly in those days. Whereby if you had someone that was just doing just superficial cuts all the time, he was told, in no uncertain terms, he was wasting everybody's time. Nine times out of ten, he didn't do it again. (Bernie, officer, 129-133)

> I would say that there are prisoners in this gaol that have killed themselves and died that were not suicidal. They weren't like what you would describe as clinically suicidal. But they were, they were almost forced into it, by the, by the system. The system that makes you, that puts all this (2) not pressure onto them, but it makes them feel that they have to make do something [...] It may be a bizarre way of looking at it, but if you put somebody in that situation in the end they start believing it. (L: um) you know, they start believing that they are suicidal. And in fact what they were originally was just pissed off because they are in prison. A little bit down, because they've seen their family. And that's all they were. (Luke, officer, 208-212, 201-205)

Nine healthcare staff also seemed to resist, and occasionally resent, the current "care" approach to prisoner self-harm, and perhaps even more so, their being (and being expected to be) the "caring ones". For instance, according to Isabel this made nurses especially susceptible to being manipulated by prisoners - who would "repeatedly" and "deliberately [...] cut themselves" and then "expected" and had to be treated (192-193). Moreover, being the "caring side" also meant being "expected to cope with anything", and "they [other staff and prisoners] don't see nurses as an individual, as a person. They just see you as a caring person" (315-316).

In addition, this role and associated expectations were said to be a frequent source of conflict with officers, who healthcare staff described as having (and being allowed to have) a different, and more punitive work ethic (see also Maeve & Vaughn, 2001), and less insight into prisoner self-harm. These tensions were perhaps exacerbated by the rather recurrent feeling that officers and "security always come first" (Hazel, 193) (see also Watson et al., 2004), and by what Peter described as the medicalisation of self-harm. In his account, "officers (.) do not understand the, the, the, the pathology we are dealing with" (238-239) in relation to a prisoner (seemingly) self-harming to "increase his medication" (247-248). As a result, "the problem is medicalised. So what work (.) officers will be doing is to try and get the nurses to get something prescribed for, for, for the patient". In turn, "the nurses under pressure will also push that pressure onto the doctor who's around that day" (239-242), often ending up "between the devil and the deep blue sea" (Lee, 60). Whilst the medicalisation of self-harm has been mainly discussed in relation to its (negative) effects for those who self-injure (Johnstone, 1997), Anthony and Lee pointed out some of its implications for medical staff. In their accounts, this "pressure" could leave nurses "feeling demoralised", because - at times - it

"pushed" them to "compromise" and "negotiate" their clinical role, for a "quiet life" and/or for fear of "how you as a clinician will be perceived" (Lee, 133-134).

7.1.4 "Draining" "Positive Efforts"

Another recurrent theme was that prisoners repeatedly harming themselves would (also) "drain" staff's "patience", optimism and their "bothering" or "trying to help" (see also Pannell et al., 2003). Again, the issue was not necessarily having to deal with frequent incidents of self-harm, in general, but rather their dealing with the same prisoner "over and over". Whilst three reported feeling closer to the prisoners concerned as a result of this "ongoing interaction", most described this as "wearing", with negative implications for both prisoners and staff. For instance - and along with 21 other officers and medics - Hazel (healthcare staff) commented that this could affect the sympathy or concern staff were able to feel towards or demonstrate to such prisoners, making the relationship "go stale":

> So when he does it, any gesture, it's very hard to go 'oh, my god, it's really so so wrong and (.) poor thing' kind of [...] when you sort of, for the 7th time gone taken him to hospital, treated the wound, and (.) I think it just set (2) this relation can go a bit stale. (305-306, 108-110)

Whereas with "the others" staff felt they could "see a light at the end of the tunnel" (Jonathan, officer, 253), dealing with those who "continually" self-harm was considered by nine interviewees to be stressful for "the actual fact that they keep self-harming" (*Ibid.*, 262):

> I think that's more frustrating than the actual act that they are carrying out. ..hh we've advised them to talk with us, and they don't. They still resort, they've got to kind of, still self-harm. (Carol, officer, 458-460)

> Basically there was nothing, I mean, you could do for him, I mean, make you feel (.) sort of useless. (Oscar, healthcare staff, 97-98)

> Ehm, the chronic one i:is, you know, you think 'what can I do. What else can I do?' (L: um). That's how I feel. (Jane, healthcare staff, 182-183)

For some, "knowing that it's all going to happen again" (Norma, officer, 468) was particularly frustrating, because "we always, ehm, the main role is to try not to let someone self-harm" (Frida, officer, 369). Indeed, and consistently with previous studies (Boyes, 1994; McCarthy, 2003), not being able to do so was the most challenging aspect of dealing with repetitive self-injury, for nine of the officers and healthcare staff

interviewed. On the contrary, managing to stop or prevent self-harm - however rare - were considered by five officers and nine healthcare staff to be two of the very few rewards of this area of work.

7.1.5 Fears and "Risks" in Dealing with Repetitive, Non-Suicidal Self-Harm

Often, this theme was also discussed in relation to fear of the possible repercussions of self-harm on staff themselves, especially in case things went "horribly, horribly wrong". In this context, having a "duty of care" was, once again, described as a source of stress, fear and frustration, because it meant that "it's your responsibility" (see also Fieldman, 1998; Hayward et al., 2005). This, in turn, was said to leave staff feeling vulnerable in dealing with self-harm and "quite isolated", from both colleagues and managers:

> Nobody wants to really, when such a thing happens, you, you s, you tend to be the only person involved. Because nobody wants to get entirely involved in such a situation. Just in case that person try and hang themselves. Nobody wants to be taken to the coroner's inquest, and, you know, ehm, you know, possibly being blamed for what happened, during the period of the person cutting themselves. So you tend to be quite isolated. (Gareth, healthcare staff, 176-181)

To this extent, self-harming prisoners were constructed as a "risk", to themselves, and, above all, to staff. As a well as threatening their job "security", self-harmers were sometimes said to pose a "risk" to staff's physical and mental health. For example, Luke and Kevin spoke of the worry of not knowing "what the person has got in his blood stream" and of dealing with someone who self-harms and "is HIV as well":

> P: I must say that the self-harmers, particularly are a group of patients who will, you know, increase our workload, increase our adrenaline, increase our, you know, our (2) risk concerns from time to time. {Coughs} excuse me
> L: risk concerns for staff themselves?
> P: for staff, yeah. And about, you know, safety issues because there are, you know, I think {coughs}, it's not very easy, you know, for some people, to see blood all the time, you know, splashed all over the walls, on, in the cells; so people can get a bit jittery about that. (Peter, healthcare staff, 190-196)

7.1.6 Alternative Staff Reactions: Mixed, ambivalent and 'split' responses to self-harm

As previously reported in the literature (see e.g. Batsleer et al., 2003; McAllister et al., 2002; Simpson, 1980), these concerns and "frustration", albeit predominant, were not the only reactions to repetitive self-harm reported by staff, nor did they seem to preclude

the existence of other, and, in some cases, more sympathetic, responses. For instance, Olivia (officer) described her feelings towards "self-harm people" as being ambivalent:

> I'm a bit (.) half and half on the self, self-harm people. Sometimes I find it a bit of a shock factor, that somebody can actually put a blade to their, to their body, and, and open their skin. But, on the other hand, I've got (.) I'm quite compassionate of people who do, do self-harm. (74-77)

From a psychodynamic perspective, the encountering of potentially contradictory feelings, in response to the same person and behaviour, may lead staff to 'split off' such responses. In other words, to protect themselves from the anxiety created by being "half and half" in relation to self-harm (Batsleer et al., 2003), individuals may polarise "good and bad feelings" (Rayner et al., 2005). In turn, this may lead to some types of self-harm and 'self-harmers' being perceived as "all-good" and "deserving" (Spandler, 1996), or at least more so than others (see also Ch. 3.1.2).

Such 'mixed' and "split responses" (Batsleer et al., 2003) appeared to be rather recurrent themes in the data. For example, seven interviewees mentioned feeling sad, depressed and "touched", *especially* "if you are dealing with a person who is a serious self-harmer, and a person who is really depressed" (Craig, specialist, 136-137). These 'split assessments' were thus seemingly influenced by staff's assumptions about different types of self-harmers, and, in a few cases, about different types of masculinities. Indeed, in Norma's (officer) account, these were closely intertwined:

> I also think, depending on (2) BLOKES CRY and being upset gets to me. If they are a proper blokey bloke (L: um), I think 'god!', you know, a bloke like that isn't going to just cry or self-harm for no reason, so I feel it. But when you get, like, the ex-drug users and all this, and they are just doing it because (2) I don't know why they are doing it? It just doesn't make any, I just think to myself 'GOD,YOU ARE A MAN, for god's sake'. (421-425)

7.2 The Impact of Self-Harm on Oneself versus 'Others'

Often, staff's reactions to self-harm were not only split in relation to the type of self-harm (and self-harmer) concerned, but also depending on whether the responses being discussed were one's own or other people's. As noted by Kiely and Hodgson (1990, p. 570), "officers [and other prison staff] are more willing to point out the effects of the stress experienced by work colleagues than themselves". In relation to "others", dealing with this behaviour was said to be a potential cause of absenteeism, anger, fear and

depression. For instance, according to Hazel this area is "something that they [nurses] find the hardest, the hardest thing to deal with [...] I think it's the first group of people that nurses kind of get burned out and weary" (416, 81-82). Gail (specialist) also expressed her "concern" that:

> We do have in most establishments several members of staff who are self-harming. And whether that's because of (.) mirroring, or whether it's because they see that just (.) it obviously does some good, so I will (2) or whether it would happen anyway. (L: um) I don't know whether they would have done this without seeing others doing it, I really don't know. But we do have quite a number of staff who [...] it's mainly female members of staff, bu:ut (.) right across the estate. Ehm (.) I wouldn't like to say that male members of staff don't do it; I can't. I've seen 1 or 2. Ehm, I suspect there are a lot more, but they will not admit it so freely. (160-170)

Indeed, one of the male officers interviewed spoke of when he himself used to self-harm "every other day", which, however, he felt had helped him "relate to them [self-harming prisoners]" and "sympathise to a certain degree". Although his own self-harm may have not been directly linked with this aspect of work, he commented that it may well have been exacerbated by pressures of the job, and the fact that "I was working here at the time, yeah. And I had to keep all that quiet, and everything else. It was quite difficult ..hh" (Luke, 543-544):

> I mean the self-harm wasn't related – or it may well have been related to that, I don't know, but I don't think it was. I mean self-harm was so more personal issues, but, ehm, in reality, sometimes I think that maybe if I wasn't a prison officer at that time, it might have not been as bad. (L: um) this is such a stressful job. (*Ibid.*, 984-988)

However, and as implicit in 17 other accounts, Luke also commented that most people would be reluctant to "disclose" how they felt personally affected by their work, including that with prisoners who self-harm:

> I don't think you would have a lot of people talking, talking about it, especially from male colleagues. I doubt you'd get many, many men talk about how it affects them. They probably just say 'oh, it doesn't bother me'. (Frida, officer, 480-483)

> This is what happens is most nurses in prison want to appear like they know what they are doing. So nobody really wants to disclose that; I've had, I, I've been having, I've had a problem I could not manage the situation. (L: um) everybody wants to be known to be doing what they x, they know what they are doing. (L: yeah) because you can't know – when 90% of somebody cuts themselves, no one is going to be saying 'oh, I couldn't, I couldn't handle the

> situation'. No, no, no, no! They [inaudible sentence], you know. You know. You are a nurse here. Ehm, people here treat you differently. (Gareth, healthcare staff, 350-356)

7.2.1 "It Is Kind of Annoying [...] but at the End of the Day {laughing} That's Why We Are Here"[19]

Particularly when discussing one's *own* reactions to self-harm (which was the main focus of most interviews), dealing with this issue tended to be constructed as a pragmatic, rather than an emotional issue, and as being "just part of the job" (Jonathan, officer, 340). For example, amongst officers repetitive self-harm was often constructed as an "annoyance" and a "drain", rather than something that "affected" them, as such. Officers were more likely to talk about this issue as having an effect on the regime, time and resources, rather than on staff themselves. This was despite five of them also describing flashbacks and nightmares about self-harm, "taking it home" - and sometimes "taking out" on their family - and, in one case, avoiding night-shifts to try and steer clear of "major incidents":

> And these are the things that have become quite regular for me. But I deal with them. I don't, don't (2) it doesn't (2) cause me depression, but it's something that's reminded (1) flashes of this (2) flashbacks of this thing happening. (Olivia, 240-243)

Whilst seemingly more open to admit that this area of work did indeed challenge and "affect" them, healthcare staff also discussed their concerns in relation to self-harm in rather un-emotional terms, mostly emphasising the practicalities of this area of work, such as the "extra burden" of having to fill in lots of paperwork or doing constant "watches" when prisoners self-harm or "threaten" to do so:

> Because sometimes you think 'oh – is he going to self-harm again?' [...] You know, you have to document it here, in the observations, you know. Things to fill in, and, you know, xx call the doctor, to see them. You know, ehm, I mean, you don't want to be doing this, you know, on a daily basis. You know, ehm, one incident, ehm, after another. You know. Yeah. It can be stressful (Peter, 387-392)

[19] Anthony, healthcare staff, 258, 263-4.

7.2.2 "With Time (.) Its Emotional Impact Kind of Dissipates"[20]

Whilst these themes may seem surprising considering the frustrations and difficulties of which so many spoke, 22 interviewees implied that this unemotionality (or façade of unemotionality) may be a sign that staff learn - and *have* to learn - to "switch off" from self-harm. Whilst one's initial responses to self-harm were predominantly described in emotional terms, the majority of interviewees reported becoming gradually "desensitised" to this issue, eventually "getting used to" the "shock", "horror", "hurt" and "disgust" of "the first time" (or times).

In this context, "building up a tolerance" and "switching off" were common themes, not only in relation to one's reactions to self-harm, but also to specific self-harmers:

> So you do sort of like build up a tolerance, for someone self-harming. I mean before, when I used, when I used to, when I first started and I saw someone self-harm, I did sort of like get emotional? But after a while you just build up sort of like a tolerance, especially if you see the same person coming constantly in and out of prison, who are doing the same things [...] and I mean, it's really BAD really, but you just sort of like, emotionally, you just sort of like, you just switch off. (Frida, officer, 398-402, 606-607)

In some cases, staff seemed to take active - and avoidant - steps to learn to switch off from repetitive self-harm, as well as other aspects of their work. "Humour" seemed to be a particularly recurrent way of doing so, including "having a laugh about it" with colleagues, as well as taking "the piss out of the prisoner" – though "most of the time" not "to their face". In addition, and particularly when referring to how other staff dealt with this area of work, interviewees also mentioned "not talking about it", "turning to drink", and avoiding dealing with prisoners who self-harm "if they do it again and again".

More often, however, this process of "switching off" and "leaving work at work" was described as something that happened almost spontaneously over time; "it just comes with experience":

> I suppose you also do get hardened after a while. I mean (.) self-harmers it's another thing that happens. You start to, ehm, you know, you've seen so many of them that after a while you stop noticing them. It's not that (2) if you are in the street, and, and you, you see somebody self-harming, you are

[20] Kevin, officer, 402.

> quite shocked by it, and taken back. But here, when it happens on a daily basis, and you've got a couple on each landing, whatever; it's not very impressive anymore. (L: um) so:o, it's (2) it's funny how that happens. (Erik, officer, 294-299)

Whilst the chronic nature of repetitive self-harm appeared, in itself, to be a cause of stress and frustration, for 11 officers and seven healthcare staff it also meant that this eventually came to be seen as "an everyday thing in prison", and thus "part and parcel of the job", "not a big deal anymore", and only one of many stressful things happening in prison - a lot of which more "serious" and violent than self-harm. For instance, according to Luke (officer) self-harm "is not really classed as being anything serious" (873), whilst for Frida (officer):

> Mostly the main concern is suicide, or people threatening security or (2) so I think that self-harm is just always seems to be a little bit of a cry for help, that just, that 10 minutes of your time. (536-538)

7.2.3 "Switching Off": Coping or burnout?

Whilst the process and stages of "switching off" were described with remarkable consistency by many interviewees, there seemed to be less agreement as to whether this could or should be seen as a symptom of successfully coping with this area of work or, quite the contrary, of being "burned out".

On the one hand, 17 interviewees implied that "building up a tolerance" to self-harm is a necessary, but perhaps maladaptive, defence mechanism, that prevents staff from "taking stuff home". To this extent, "switching off" was often constructed as a positive process, a sign of having learnt to understand and cope with self-harm, and of "knowing where to place your stuff, and your responsibilities" (Anita, specialist, 181-182):

> I like to feel that I can shut off, because if I can't, I feel I would find life very difficult outside. (Craig, specialist, 286-287)

> I think the more you are in touch with your own feelings, the better you will respond. But on the other hand, I also understand that you, you have to be a very strong person; and in, in many ways, it's not functional to sit and talk about every time something happens, because you might just be paralysed by it, you know? It's, it's a coping mechanism to get on with things. (Anita, specialist, 267-271)

Particularly amongst officers, becoming somewhat "hardened" was not only described as desirable, but was often said to be a necessity, on both cultural and pragmatic grounds:

> There is (.) stigma attached to being a, ehm, a care bear, they call them in here - in the Prison Service - officers who care too much. Ehm, it's almost uncool to (.) to care too much [...] People like to be, ehm hard, and, and unaffected by what's going on in here. (Erik, officer, 248-250, 292-293)

The pressures of "keeping the regime going" also meant that staff often felt they had no time to be emotional. As commented by Ian (officer): "well, we have to, at the minute (2) it's not your decision, you've got to deal with it. You've got no choice" (175-175). In this respect, "switching off" was not only constructed as an individual coping mechanism, but a form of collective coping (see Ch. 4.6.1), a "culture of bravado" (Anita, specialist, 253) that had become part of the "prison ethos":

> The whole ethos in this prison seems to be 'IT'S HAPPENED. GET OVER IT. CARRY ON because we've got to, we've got to let them out for feeding or, or exercise, or something. (Bernie, officer, 284-286)

On the other hand, and particularly when discussing *other* staff's reactions to self-harm, "shutting off" was sometimes described as a symptom of "burnout", "emotional blunting", and of not being able to deal with or understand self-harm:

> So if you don't understand you, you shut off from it. (Luke, officer, 762-763)

Implicit in many accounts was that the idea that becoming desensitised to self-harm did not mean having no thoughts or feelings about this, but was actually associated with becoming intolerant of self-harmers, "cynical" or "blasé". Comments such as "if you are going to do it, do it properly" (David, officer, 154-155), "it's your own skin, so do whatever you like" (Kevin, officer, 259), and "pull yourself together" (Luke, officer, 228) were, by staff's own admission, "not unheard of" (David, 154). Whilst this may well have been staff's "way of dealing with it" (Luke, 687), some questioned whether this process may be considered to be positive - not only for prisoners (see Ch. 6.2.4), but for staff themselves. For example, Frida (officer) identified her building up a "tolerance", with "the point where you think to yourself 'why are you wasting my time? Why are you doing this? You can get this, but you just have to wait, and be patient'. So

you do get sort of like angry and flustered in that sort of way" (583-586). This, for Hazel (healthcare staff), is also the point at which staff begin to feel "burned out":

> You hear all the nurses say 'I just can't be bothered with these people that (.) aren't unwell as such, and just want to get themselves attention' and all that kind of stuff. It's like (2) when you get to that sort of point - is it burnout? - and I think it's the first group of people that nurses kind of get burned out and weary. They kind of get angry at that group because they see them as sort of being able to control it. (79-83)

For two interviewees, keeping (and having to keep) this anger in check was the most challenging aspects of dealing with this issue. Ten others commented on their (having to) "remain professional", even when feeling annoyed and despondent. Whilst the accounts of prisoners and of staff themselves suggested that many may not be very successful in doing so, Ben (specialist) commented that, those who are, may then experience "cognitive dissonance" - for the potential detriment of both prisoners and staff. Indeed, this "conflict between the emotions they feel about their job and the required emotions the organisation has determined to be acceptable for display" (Tewksbury & Higgins, 2006, p. 291) has been repeatedly shown to be an "antecedent" (*Ibid.*) of work stress and burnout, as well as poor job satisfaction (see e.g. Rafaeli & Sutton, 1987).

Even when staff were seemingly more "blasé" and less angry about self-harm, this was not necessarily considered to be positive or desirable, for either staff or prisoners:

> From a humanitarian perspective that equally is just as concerning (L: yeah), because people who – because what does that suggest, emotional blunting? And if you've got emotional blunting going on with people, what does that suggest about the possibility of recognising their true needs [...] And I guess one of the questions that we are asking is why is that not distressing to staff? (L: um) and the other question that we might be asking is what is the impact that that is having on staff, even if they don't appear to be distressed (L: um), i.e. what, how do they make sense of that behaviour? (Ben, specialist, 17-20, 163-166)

According to Ben, in order to understand staff's reactions to self-harm, one should not only consider why this area of work might be "distressing" for staff, but also why it might not be – or not "appear to be". To this aim, it is useful to (re)explore the ways in which they "make sense of that behaviour", and how these may function to protect them

(or not) from the potential stress of dealing with self-injury. It is to these points that discussion now turns.

7.3 Why May Staff Not *Be Affected by Self-Harm? "Rationalising" and "passing the buck to another department"*

A recurrent theme amongst both prisoners (see Ch. 6.2.6) and staff was that the (often negative) ways in which staff spoke of self-harm and 'self-harmers' were "their way" of "rationalising" and dealing with the difficulties and uncertainties of this area of work. Indeed, in describing his own "becoming immune" to self-harm, Kevin (officer) commented:

> You try and think about it, but then you can't work out why they do it. So, at the end, you just rationalise, 'well, we all make choices. That is his choice.' (L: um) you know, he must have been born with a few lose screws in this mind, do you see what I am saying? (170-173)

Kevin's account reflects two important and recurrent themes. Firstly, that this process of 'rationalising' may be a symptom that staff "need to develop a bit more of an understanding why" (David, officer, 157-158). For instance, Norma and Luke, who were the only two officers to have had some "personal experiences" of self-harm, felt that most officers didn't have "a clue why they do it" (Norma, 337-338), and thus tended to draw their own - "unsympathetic" (Luke, 673) - conclusions. Both prisoners and staff suggested that, in turn, this may be related to their lack of training on self-harm. Indeed, when prompted, only two members of staff expressed satisfaction with current provisions for training. Most others complained about the lack of training, which was reportedly a) mainly about suicide (not self-harm), and b) concerned with "paper work", rather than "care". For four interviewees, this meant that staff may find it "hard to (1) know how to manage [and] what to do in certain situations" (Erik, officer, 61-62), in turn making one "more likely to react to it in a negative way" (Anita, specialist, 331). Although in-depth, "proper" training was said to be available, this was only open to those who were willing to become ACCT assessors (see glossary), an extra responsibility that some staff seemed reluctant to accept – or at least "unless everyone's going to have it" (Norma, officer, 539) (see also Ch. 8).

A second theme highlighted by Kevin's account was that staff's way of rationalising prisoners' self-harm can function to shift responsibility and blame away from oneself. In Kevin's case, portraying self-harm as a "choice" and a sign of having a "few loose screws", may serve to do so in two ways, as it simultaneously constructs it as a rational "challenging behaviour" – which for many meant that it should be ignored or even punished, but never "rewarded" with "attention" – and as being the responsibility of healthcare staff:

> Staff will look at it, and think: 'well, if he's constantly doing it, why are we looking after him? I'm a prison officer. I deal with prisoners. I deal with, with (1) with discipline problems with regards to prisoners. And because that's the way we are trained, this guy should be in hospital. If he's continually cutting himself he should be in hospital, on the hospital wing (2) [...] it's not my job [...] we are trained to deal with bad people. We are not trained to deal with, ehm, I say (2) you know where I'm coming from (1) we are not trained to deal with mad people. (Luke, officer, 757-761, 767, 778-779)

A related theme amongst officers was the idea that "chronic self-harmers" should be "given to somebody else" and "taken off the wings". This "passing the buck to another department" (Lee, healthcare staff, 68) also seemed to be a recurrent theme amongst the other staff groups interviewed. As a result, rather than being "everybody's responsibility" (HMCIP, 1999), repetitive self-harm often seemed to end up being nobody's concern. For instance, for many healthcare staff prisoners who repeatedly self-harm were not "unwell as such" (Hazel, 80), and were therefore a 'problem' for officers and psychologists, rather than themselves:

> [I]t's a management thing more than anything [...] ehm, basically the officers are mainly involved with the daily management of the prisoners, and x activity thing. (Anthony, 443-444, 161-162)

> Well, sometimes I just feel they are still behaving as babies. And perhaps that's part of their pathology. It's like these are adults who are x inadequate, in terms of their personality, xxx. Again (4) with that kind of constantly in mind I just feel that perhaps there may be something else that can be done for them, you know, which I'm not going to be able to provide, you know. (Peter, 134-138)

Even specialist staff, whose constructions of self-harm were arguably more sympathetic towards prisoners, ended up commenting that managing or preventing this behaviour was outside of their competency and "control". Perceiving this behaviour as being

related to "deep issues" from one's "past" meant that "of course they then need specialist (.) help. It's not something that I feel capable of dealing with, or I feel I can sort of support them" (Craig, 88-90). On the other hand, when specialists did appear to consider the role of current and prison-related factors in precipitating self-harm, they mainly seemed to emphasise the key role of *wing* staff with prisoners who self-harm, rather than their own.

7.3.1 "There Is Nothing You Can [or Should] Do, to Help Them"[21]

In some cases, staff did not only resist their own responsibilities in dealing with self-harm, but the very idea that anyone may be able (or should aim) to stop, manage or prevent repetitive self-harm. This, in turn, seemed to be associated with two main discourses: one pointing to the inadequacies of self-harmers, the other to the inadequacy of the system itself. It is to these that discussion now turns.

As discussed in Chapter 5, most interviewees seemed to construct self-harm as something intrinsic to the individual – be it a medical or psychological inadequacy, or a troubled past. This can mean that "you will not stop them, because that's the way they are" (Harry, officer, 273-274). This, in turn, may have a number of implications, most notably that "there's no point. Because you can't help them" (Norma, officer, 367). According to Ed (healthcare staff), there is no point in even asking them why they do it, as with the "ones who do it a lot [...] you are just going to get the same old [story]" (155-156). Particularly in relation to prisoners who were alleged to self-injure for attention and/or drugs, seven officers and four healthcare staff commented that a) there was nothing anyone could do to stop them ("I don't think there's anything you can give them. I think you are always going to have people who want attention" (Matthew, officer, 461-462), and b) that responding to their self-harm, and "giving into them", might actually encourage further self-injury.

Others pointed out that, even if it were possible to "cure" self-harm, prison would not be the place to do it:

> You are never going to cure them. Well, you are never going to cure them, but I don't, I don't think (.) I don't think it's really in our scope to cure

[21] Norma, officer, 363.

> them [...] we are ill equipped really to cope, really. Because a lot of people who repeatedly self-harm perhaps ought not to be in this setting. (Frank, specialist, 159-165)
>
> Ehm, yeah but it's not, ehm, not, not anything really that could be done in a prison. It's a, I think it goes back a long way. I think, a lot of the, I think a lot of services outside have failed these guys, and they've come to us as a last port x. It is a last resort, anyway. When you think we should be doing in prisons, is to rehabilitate guys in 6 weeks or so. After 20 years of mismanagement outside here. (Ed, healthcare staff, 103-107)

Some of the implications of these themes, and the others presented in this chapter, are discussed below.

7.4 Discussion

As previously reported in the literature (see e.g. McAllister et al., 2002; Ramon, 1980), many of the staff interviewed spoke of their frustrations whilst working with prisoners who self-harm. The term "frustration" was applied to a range of concerns, feelings and "annoyances", some of which were constructed as being inherent in this area of work (or better, in self-harmers themselves), and others that were precipitated and/or exacerbated by their roles with such prisoners, and the lack of available resources. Being "short-staffed" and "over-stretched" seemed to be particularly central to officers' responses to repetitive self-harm, with some making direct links between the level of resources available and their reactions to this behaviour. In turn, these concerns seemed to tap into a more general feeling of powerlessness and low "job control" (Cox, 1993; Karasek, 1979). Not only did officers feel little control over the time and resources available to them to deal with this issue, but also a) over a system that was letting "attention seekers" manipulate them, and divert their energies and resources from the "real people", and b) over a behaviour that they did not always understand or know how to manage, but had to try and "stop".

This arguably "unrealistic" and potentially counterproductive role (see e.g. Shaw & Shaw, 2007; also Ch. 6.2.5 and 9.6.1) appeared to be a greater source of conflict than its potential clash with officers' security role. Indeed, whilst much of the relevant literature suggests that this "dual caring and security role" (Walsh, 2005, p. 67) is a major source of stress for officers – particularly in dealing with prisoner self-injury – this theme was

noticeably absent from the data, possibly because many did not feel they had the time or training – or in three cases the inclination – to fulfil a "caring" role. Theoretically, the concepts of role overload and role ambiguity (rather than role conflict – see Cox, 1993) were seemingly more relevant to officers' responses to self-injury. Following "a cultural change in the role of the prison officer", they were expected to "do 100 other things", including:

> Personal officer schemes, answer obviously any queries and issues that prisoners have, as well as do all of the security aspects of their job, and the discipline, and control aspects, of dealing with prisoners on their wing. Not only have they got that, but they've also got to then manage a prolific self-harmer, that's on x wing, and that can be quite time consuming. (Enid, specialist, 458-462)

Doctors' and nurses' main difficulties in dealing with repetitive self-harm were also discussed in relation to their professional roles with self-harmers, and especially to their having to "care" for them. This time, however, lack of training or resources were not particularly recurrent themes, nor were the pressures of "stopping" self-harm. Rather, being – and being expected to be – "the caring ones" seemed to be resisted, and occasionally resented, because of how it positioned healthcare staff in relation to both self-harmers and officers. In this context, feelings of vulnerability were frequently mentioned, both with regards to being (and being held) "accountable" in case things went "horribly, horribly wrong", and to being "pushed" and "pressurised" by both prisoners and officers.

These findings suggest that, whilst much of the literature has focused on how doctors and nurses may negotiate (or not) the care they provide in prisons (see Ch. 4.7), the more fundamental questions of what is meant by "care" has perhaps been overlooked. Implied in the accounts of both prisoners (see Ch. 6.2.3) and staff was the idea that medical staff should (also) care for prisoners on an emotional level, whilst remaining themselves unemotional, "not getting upset" and not "really bring[ing] personal things" (Isabel, healthcare staff, 314-315). Yet, more than half the healthcare staff in the sample were not trained to deal with psychological or mental health issues. Rather, they had been trained to provide *physical* care, in relation to general-practice and substance-related complaints. Thus, it is questionable whether one can or should condemn as negligent and uncaring what both prisoners and nurses themselves constructed as "*just* patch[ing

prisoners] up" (Tom, 128) or "*just* attending to the medical needs at the moment" (Ed, healthcare staff, 159-160; emphases added). Arguably, there need to be clearer messages as to what is expected of healthcare staff (both in prisons and outside), and, depending on one's specialism(s), what falls outside a professional's competency and responsibility.

Overall, these findings lend support to the previous literature in suggesting that working with people who self-harm can be "draining" and "challenging" for staff (HMCIP, 1999; Liebling, Tait, et al., 2005; Paton et al., 2000), and that these difficulties are usefully conceptualised within the context and content of one's work (see Ch. 3.1.3). Arguably, more attention needs to be paid to this traditionally neglected area of policy and practice, and to its wider implications for the "smooth running of prisons" (Liebling et al., 1999). As highlighted in the accounts of staff, negative reactions to self-injury may not only affect prisoners' welfare, but can also be indicative of staff stress and burnout, and be associated with absenteeism, depression, "flashbacks", or even self-harm.

On the other hand, some staff seemed almost to play down the impact of this area of work, particularly when discussing their own reactions (as opposed to other people's) and when considering how prisoner self-harm affected them on a personal (rather than a professional) level. Implicit in the accounts of 12 officers and 11 healthcare staff was the idea that working with prisoners repeatedly self-harming was challenging, draining and frustrating, but not traumatic nor stressful per se – or, at least, not for oneself, and not over time. Indeed, in some cases dealing with self-harm was described as being relatively "boring" and "minor" when compared with the other pressures and difficulties faced by staff in prisons, especially assaults and self-inflicted deaths. In addition, many interviewees implied that they had - and had to - become desensitised to self-harm, which allowed them to deal with this aspect of their work. As further discussed in the following chapter, this was also reflected in the recurrent report that staff do not *need* to be "supported" in relation to this area of work. At the same time, however, some of the tensions and inconsistencies in participants' accounts suggest that this process of "switching off" may not be as clear-cut nor 'positive' as implied.

7.4.1 "Switching Off"?

Becoming desensitised was mainly conceptualised as a strategy of *emotional* detachment, which for many was both a practical necessity and a cultural expectation. Not only was there no time for staff to "dwell" on incidents of self-harm, to remain emotional about this issue (over time) was described as being not "the done thing", "uncool" and potentially unprofessional. Whilst strategies of depersonalisation, humour and emotional detachment have been reported to be common amongst prison staff (e.g. Arnold, 2005; Crawley, 2004), and 'caring' professionals more generally (e.g. Dyregrov & Mitchell, 1992; Henderson, 2001; Van Wormer & Boes, 1997), the pressure to be "hardened" and unemotional may be especially high in relation to repetitive self-harm. Firstly, "he's not your mate, he's a prisoner", and, in the words of Crawley (2004, p. 149), "it is much less acceptable for an officer to admit that prisoners are causing stress, because controlling prisoners is one of the officers' core function". Within the 'macho' culture of prisons, the view of (certain) self-harmers as "soft lads" who need to "grow up and be a man" may render this even less acceptable.

Secondly, in view of the behaviourist notion (see Johnstone, 1997) that self-harm is a "learned" "challenging behaviour" (Norma, officer, 293), and that some self-harmers "get off on, on that type of reaction" (Olivia, officer, 292-293). In this context, being emotional may be perceived as "giving into him" and "playing his game", which may encourage further self-injury, and further "threats" of self-harm. To avoid "rewarding" self-harm with care and attention may thus mean avoiding "positive reinforcement" (Norma, 41-42), and "maybe I get a response from them, and then maybe it gets them thinking, you know" (Ed, healthcare staff, 163-164). At the same time, "if you give it too much attention then prisoners end up controlling you, and getting, getting whatever they want, simply because they (.) you know, they, they say they are going to self-harm" (Erik, officer, 63-65).

On the other hand, Erik himself commented that "if you ignore it, then you might end up with, you know a serious situation on your hands" (62-73). Similarly, Olivia (officer) argued that being "upset" and "panicking" about self-harm may be less risky than failing to do so:

> They were saying that, what it is, that's what he wanted [...] I don't care! {laughing} I don't care what, what he gets off on (L: um). I do not get off on seeing somebody stab himself in the neck. I don't care. I might manage to xx, I'm just going to stop them from doing it. (291-295)

As noted by Anita (see section 7.2.3), it may well be adaptive and "functional" for staff to maintain some degree of "social distance" from prisoners (see also Clarke, 2004; Roger & Hudson, 1995). Indeed, as implied by some of the prisoners, an excessive level of emotional involvement is not necessarily what they would want, need or expect from staff (see Ch. 6.2.5). On the other hand, it is notoriously difficult to establish what may represent "the right level of social distance" (Liebling, Tait, et al., 2005, 163), or to draw a line between a "functional" level of emotional detachment and "emotional blunting", "burnout" (Maslach & Schaufeli, 1993) or "compassion fatigue" (Figley, 1995). Even if it were possible, staff would be unlikely to occupy one position or the other, in a rigid and static way. As Goffman (1961, p. 79) suggested, they may be more likely to experience "an [emotional] involvement cycle":

> The sympathising staff member may feel he (sic) has been 'burnt' and retreat [...] Once removed from the dangers of inmate contact, he may gradually cease to feel he has reason to be wary, and then the cycle of contact and withdrawal may be repeated again.

It would be inappropriate to conclude that being "switched off" from self-harm is either (always) 'good' or 'bad', for either prisoners or staff. Moreover, and particularly in the context of such strong cultural resistance to most things 'emotional', it is arguably impossible to conclude whether staff's not being "affected" by self-harm (a term which may invoke and orient participants towards feelings and emotions) may be part of a "performance" (Billig et al., 1988; Crawley, 2004), or a 'real' reflection of "what's in their minds" (Willig, 2001, p. 88) – nor is this necessarily relevant. As argued in Chapter 4 (see section 4.7), the main significance of the "stories" professionals tell about themselves is "not so much in whether they are true or not, but in that they may influence the care that is given" (Cooper, 2001, p. 36). Whether or not staff were actually able to "switch off" from repetitive self-harm, and regardless of how they may have constructed their emotional responses to this issue, it may be argued that these

discourses can have 'real', material implications for prisoners in their care, and for staff themselves.

Being emotionally "desensitised" did not seem to exclude the display of traditionally "manly emotions" (see Crawley, 2004), particularly anger and frustration. Indeed, "building up a tolerance" to self-harm was frequently associated with becoming intolerant of self-harmers. Perhaps surprisingly, the potential effects of this on staff were rarely acknowledged, particularly with regards to those who may themselves self-harm or be close to someone who does. On the other hand, 17 interviewees suggested that levels of prisoner care may suffer as a result of staff becoming "cynical" and "angry". Although prisoners themselves spoke of these reactions as being "understandable" (see Ch. 6.2.6-6.3), like staff they commented on the variety of unhelpful practices and discourses with which they may be associated, including "blasé" and resigned attitudes, and "do it properly" type remarks. The very ways in which most staff appeared to construct self-harm and self-harmers appeared to "rationalise" punishing, ignoring and doing "nothing" about self-harm. Whether self-harming was seen as a rational "choice", the result of mental illness or "maladaptive coping" - and particularly in the context of poor resources - staff often felt it was "not their fault", and thus that "it's not up to us". Whilst this may appear to free staff of all responsibilities in relation to self-harm, it also contributed to the feelings of learned helplessness (Petersen, Maier, & Seligman, 1995; Seligman, 1975) and lack of control discussed above, thus exacerbating their difficulties in dealing with this behaviour.

These responses may be especially recurrent when working with prisoners who *repeatedly* self-harm. Previous research has shown that perceived likelihood of repetition may be negatively associated with staff optimism (Mackay & Barrowclough, 2005), which, in turn, has been found to be linked with workers' willingness to help clients (see Weiner, 1986). Whilst qualitative data from a relatively small interview study may not allow one to 'test' this chain of reactions, these results clearly suggest that the frequency or repetition of self-harm is an important - and much overlooked - dimension for understanding the possible impact of this behaviour on staff. Furthermore, the findings of this study lend support to the work-stress literature in suggesting that these reactions are particularly likely in an environment where staff are already

"stretched" and "under-resourced", poorly trained, and yet potentially accountable for the behaviour of prisoners/patients (See Ch. 3.1.3).

7.5 Conclusions

Even if staff were personally unaffected by this issue, it was clear from the interviews that their work, the regime, their energies, compassion and "patience" may suffer as a result of dealing with prisoners repeatedly injuring themselves. Setting aside academic debates over the feasibility and desirability of emotional detachment in dealing with this issue, the accounts of both prisoners and staff suggest that staff's responses to prisoners' repetitive self-harm - whatever the staff's motivations - contravene policies and guidelines that emphasise "supportive conversations", "proactive care" and "non-judgmental attitudes" (Borrill et al., 2004; Gough & Hawkins, 2000; HM Prison Service, n.d.; NICE, 2004; Royal College of Psychiatrists, 2006).

A more encouraging implication of the data presented here is that negative reactions to self-harm are not inevitable. Staff's responses to self-injury, and the ways in which they were discussed, are likely to have been influenced by a variety of factors. These include staff's (mis)understandings of self-harm, their personal experiences of this issue, and the practicalities of dealing with this behaviour "over and over" in an environment where resources are poor and "stretched". Wider working practices, cultures and "personalities" (Lombardo, 1989; Rutherford, 1993) - especially in relation to humanistic, penal harm and risk discourses (Maeve & Vaughn, 2001) - are also likely to be reflected in their accounts of this particular aspect of their work, as are dominant discourses around (male) self-harm and masculinities in prison, and cultural 'rules' about the display and performance of different emotions (see Crawley, 2004). The process of 'adaptation' (or failed adaptation) to dealing with repetitive self-harm is thus a complex and dynamic one.

Unfortunately, it was not possible to explore these factors in relation to the more positive attitudes of specialists (see Ch. 9.5.1). Nevertheless, even amongst other staff groups, not all interviewees described this area of work as "frustrating" and "annoying", or self-harmers as "attention seekers". The following chapter considers the role - and duties - of the organisation in attempting to prevent or reduce these responses. In particular, issues

around staff training, support and supervision are considered, as possible 'solutions' to counter negative staff practices and discourses.

Chapter 8. Addressing Negative Staff Reactions: The roles and responsibilities of the organisation

As discussed in previous chapters, both prisoners and staff commented that the latter tended to perceive and respond to self-harming prisoners in negative and potentially counterproductive ways. Angry, frustrated and "blasé" attitudes were reported to be common amongst staff, with implications for staff themselves and possibly even greater ones for the prisoners in their care. Exploring these reactions within the material and cultural contexts of staff's work, and in relation to their experiences of dealing with this issue, offered useful ways of conceptualising these responses. This chapter considers how locating them within the wider cultural and organisational context may also help to address and prevent some of these negative reactions.

8.1 Are Negative Staff Reactions Inevitable?

Although many staff discussed their experiences of this area of work as "frustrating" and "annoying", and portrayed most self-harming prisoners in negative terms, these reactions were by no means inevitable – or inevitably interlinked. As also highlighted by the prisoners, some staff (though perhaps a minority) appear to "care" and "really want to help", which "sometimes gets overlooked". Moreover, three interviewees reported that they enjoyed dealing with this issue, with 21 others commenting, when asked, that they found satisfaction in at least certain aspects of this work – most often "when the self-harming behaviour stops" (Oscar, healthcare staff, 164) (see also Ch. 7.1.4). Others also implied that staff's difficulties and "frustrations" in relation to self-harm "can be managed [...] or prevented from happening, from the start" (Catherine, healthcare staff, 648-649), as can the negative attitudes with which these may be associated. For instance, Hillary (specialist) commented that:

> If they [staff] had got time and the resources to do it, I think you will find that probably 95% of the staff wouldn't think like that. But it's the circumstances that we find ourselves working in that means that it happens. (312-315)

Even within these difficult circumstances, "switching off"– albeit predominant – was not the only way in which staff reported dealing with self-harm. As research on nursing in secure environment has previously shown (see e.g. Bowers, 2002; Gadow, 2003;

Holmes & Federman, 2003; Maeve, 1997), appealing to one's professionalism, focusing on the more positive aspects of work, invoking the prisoners' humanity, and setting oneself more "realistic" goals were all mentioned as possible - and positive - alternatives. Other - marginal - themes included having frequent breaks, being "self-aware", going to the gym, and, above all "getting skilled", "building up one's confidence" and "understanding mental issues". Some of these are reflected in the extract below:

> Just treat them as human beings, normal people with problems (um), and in that way, you get along with them well. Because once you treat them as, as us versus them, then you don't get along well with them, and it frustrates you. So if you sort of calm do:own, even when they push – because they do push boundaries anyway. (Maria, healthcare staff, 102-105)

> I think it (.) what helps me manage those feeling, myself, is, is (.) getting skilled. You know, making sure that I am skilled enough in my role, that I'm constantly kind of updating my knowledge base, that I'm reading, that I'm trying different things; but also that I'm not setting my goals too high, you know, that I'm not making un, unrealistic expectations of myself and of them. Because then you set yourself up for being disappointed, and burning out really. (Anita, specialist, 188-193)

8.1.1 The Moderating Effects of the Organisation

The literature on work-related stress, as well as that on professionals' responses to self-harm, suggest that it is useful to explore these alternative ways of dealing with self-injury at the level of the organisation, rather than to focus on the role of individual "buffering" factors, such as gender (see Ireland & Quinn, 2007), self-esteem, hardiness, coping skills, mastery and personal control (for a review see Carson & Kuipers, 1998). As argued by Lambert, Hogan, and Shannon (2002, p. 136) in relation to the wider literature on work stress and "staff behaviours" in prisons, this approach offers pragmatic, theoretical and political advantages:

> Although it is important to know how different personal characteristics are related to job satisfaction, correctional administrators should not focus much on these characteristics as a way to improve staff job satisfaction for two fundamental reasons. First, these are characteristics that cannot be changed, nor will society look favourably to excluding employment to individuals based on their gender, age, or race [...] [Also, these] should be

> viewed more as either descriptive or control variables rather than as causal variables [...] Second and more important, although personal characteristics appear to have some type of effect on job satisfaction, work environment factors, such as a paramilitary structure, appear to have a larger impact on correctional staff job satisfaction. Work environment is something that can be changed or addressed by most correctional administrators.

Focusing on "the moderating effects of the organisation on staff well-being" (Clarke, 2004, p. 212) may help to shift attention and blame away from individual members of staff, whilst exploring the occupational and organisational systems, structures and processes that may prevent and/or reduce their difficulties and stress in dealing with self-harm, and some of their potential effects – including negative responses, burnout and absenteeism (see e.g. Garland, 2004; Jones & Bright, 2001; Rick et al., 2002). This is arguably an especially useful approach in the context of this study, as both prisoners and staff implied that staff's frustrations and negative attitudes were mainly linked with wider occupational and organisational factors, as opposed to their individual differences and personalities. For instance, a lack of (relevant) training was often identified as a main cause of staff's limited knowledge and understanding of self-harm, whereas the shortage of staff, time and resources meant that:

> A lot of the staff do get very frustrated, at the end of the (.) they haven't got the time to actually spend with these people, to try and find out what reason (.) and that's why you will come across this 'oh, well they are just being manipulative'. (Hillary, specialist, 309-312)

These findings imply that the issue is not (or not only) that staff do not "find their own mechanisms to cope" with self-harm (Frank, specialist, 384), but rather that "we [the prison] don't give them the strategies to cope" (Enid, specialist, 357). According to Enid, "they [officers] actually like that role [... but] they need that extra little bit of support" to match the additional responsibilities and "pressures" that it brings (475-477).

Whilst this was seldom expressed as a "need" for "support", 25 of the 38 staff interviewed complained of feeling unsupported in this area of work and/or of not having the skills or resources to deal with repetitive self-harm. Despite often positioning

themselves as being able to "quite easily deal with things" (Olivia, officer, 333), many implied that "support" - or at least certain types of support - were indeed important, and may bring benefits to both staff and prisoners:

> It would be very very helpful and beneficial for self-harmers – and the staff – if they get some support [...] Because if we are kind of like relaxed; it is easier to help that person; because you know, that's where we are not careful. You know when you are stressed; you can't really deliver, ehm, quality care, when you are stressed yourself. Because [inaudible sentence], they are really stressing you, and nobody, no one is there for you. (Fay, healthcare staff, 674-680)

This chapter reports staff's views and preferences for support in relation to this area of practice. The potential benefits of different types of interventions are considered, in relation to both staff and prisoners. As, once again, there were considerable similarities across different staff groups, the accounts of officers, healthcare and specialist staff are presented together. These are then discussed in relation to clinical and applied psychological literature, and some of their practical and theoretical implications are highlighted.

Although the interviews did not specifically explore whether participants considered the provision of staff support to be a 'duty' of their organisation, the title of this chapter was chosen to emphasise that "the Prison Service has a duty of care to its staff as well as prisoners" (staff participant; as quoted in Marzano, 2004, p.1). This includes "support for the staff who care for prisoners at risk of suicide and self-harm" (HM Prison Service, 2003, p. 2). Under Health and Safety legislation, all organisations are obliged to ensure, "as far as is reasonably practicable", the health, safety and welfare of their employees (HMSO, 1974, 1999).

Please note that for the purposes of this study the notions of "support", "support needs" and "support intervention" (or "service") were employed in their broadest sense to refer to "the full spectrum of control strategies used to deal with the problem of stress in the workplace, including both individual and organisational focused interventions, and prevention, reaction, rehabilitation and cure" (Cox, 1993, p. 64). In other words, the term support is not exclusively intended as social support nor as a form of post-incident help, but rather incorporates a variety of strategies that may prevent or alleviate the

stress of dealing with self-harm, and associated strains. This may include training, counselling and supervision, as well as "concrete support with the work itself, such as shared work loads and increased personnel" (Fillmore & Dell, 2000, p. 74).

8.2 Staff's Suggestions for Support

8.2.1 "Bottom-Up" Practice

A recurrent theme in the accounts of officers, healthcare and specialist staff was that those dealing with self-harm, and particularly wing staff, need to be "empowered" by their managers. In turn, this could be achieved by encouraging, recognising and, above all, involving *all* staff in "the process", from the designing of staff training to the "decision making about how to support that prisoner" (Craig, specialist, 346). In the words of Lee (healthcare staff), staff want to "adopt strategies and policies from their own experience" (482-483), or as Luke (officer) put it: "instead of working from the top down, you are working from the bottom up" (290-291). This would not only make them feel that they are being taken "seriously", but would also mean that "this gaol [...] would run perfectly well" (*Ibid.*, 284-285).

Unfortunately, however, there seemed to be little consensus over what such bottom-up policies and procedures should be. For instance, as discussed in Chapter 7, staff views varied quite considerably regarding the amount of "care" self-harming prisoners should receive, and by whom. In addition, whilst some reiterated the importance of having a multi-disciplinary approach, personal officer schemes and people "willing to take responsibility" (Nathan, healthcare staff, 305-306), others seemed more inclined to devolve all or most responsibilities to a designated "high dependency unit", whose staff would have "the right support process in place" (David, officer, 372). Less drastic suggestions were to ensure that staff had good breaks from their work in general, and "respites" from prisoners repeatedly self-harming. However, rather than suggesting that staff be 'rotated', Anthony (healthcare staff) and Harry (officer) proposed to "get him [the prisoner] off the wing for a while", by "putting him on a lie down in some place" (166-167) (see glossary). According to Enid (specialist), this carries the danger of simply moving "problems around the prison" (567).

Alternative suggestions were to introduce an "insider scheme" amongst prisoners, to "take the pressure off staff" (Enid, 583); and employing more nurses, so that officers can "be let, left to get on with our job" (Ian, officer, 313). Reflecting what had been a recurrent - but often implicit - suggestion, Anita (specialist) also emphasised the importance of supporting and "investing" in staff, "in other areas, not just directly related to self-harm":

> You know, if you get a, a more sort of confident and competent workforce, they are more likely to deal with issues in a confident and robust way. (283-285)

8.2.2 Managerial Support and Supervision

With five exceptions, staff had reported feeling unsupported by their managers – or most of them. Whilst Luke (officer) seemed keen to exclude "management completely" (290), the majority of those who commented on this issue appeared to want managers to be more involved in the process. Carol (officer), for instance, called for:

> Taking ownership, as manager that is in control of the incident, showing that they know who was aware, being involved in the incident [...] a little bit of advice of what you could have possibly done better in the future. As I said, just thank you, at the end of the day, or (.) how are you feeling? By not a member of the PICT[22] team, or the staff counsellor, it's, you know, your manager, or your governor. That's all you want them to say at the end of the day [as soon as possible after the incident]. And they are worried about targets to achieve or (.) somebody's just lost. (628-629, 646-650)

Ann, Olivia (officers) and Jane (healthcare staff) also wanted managers to be better at "noticing that something's not quite right" (Ann, 271) with a member of staff, and:

> What work people are doing [...] The only thing that seems to be noted is people who have done bad things with the job. Which is going to be (.) xx destroy morale. (Olivia, 179-182)

According to Lee (healthcare staff), increased managerial involvement and supervision would not only support staff in dealing with the aftermath of an incident, but would also help towards managing and preventing suicide and self-harm in custody:

> I think supervision would be the, would be there – at the end of the day, the main thing that would help supporting staff is supervision, regular contact, ehm, managers who they are our managers [...] and you feel more comfortable dealing with these issues, situations. So supervision, clinical or

[22] PICT was the acronym used to denote the prison's local Care Team (see glossary). .

> managerial supervision, and (2) easy communication with the management, or your line manager. It's another way of supporting the staff. We are aware that, yes, the manager is aware of this, when it started. Not only to be aware of it when it became a problem (um). So it becomes more difficult for the officer or the nurse to handle. Because at that stage you are looking to defend yourself [...] if at the beginning the managers are aware, probably with the managers' intervention the situation will have been dealt differently. Or will have been perceived differently. (365-381)

As highlighted by Frank (specialist), this level of managerial involvement and supervision requires managers to be "knowledgeable, and some of them clearly aren't!" (367). Once again, this was related to having to juggle too many other priorities, including, as pointed out by Carol, having to achieve targets. Indeed, according to Frank, part of the issue is that while "fear, and [...] our performance at coroners' courts" are central to staff's reactions to self-harm and perceptions of support, "proving or demonstrating care for staff within the policy wouldn't really help you at a coroner's court. (6) Reality" (550-552). In his account, not being able to "pin down" what works or what might work seemed enough to dissuade him from even considering a strategy to support staff dealing with self-harm.

On the other hand, and whilst seemingly not trying to diminish the importance of managerial support and supervision, Gail (specialist) pointed out that managers cannot, and should not, be expected to be "supervisors" as such. Speaking in relation to officers involved with sex offender treatment programmes, she argued:

> Because it's very difficult – at the moment a lot of people are expected to use their line managers as their supervisors; who they want to talk the difficult cases with them, and how it made them feel, and what sort of problems and issues it had raised. But when does the line manager take the supervisors hat off, and put the management hat back on? At what point do you say: 'well, that's not right [...] Because then that becomes a management issue and (2) you know, you can't wear too many different hats. (320-327)

Moreover, Ed (healthcare staff) argued that to involve managers too closely in staff support would be "pointless" and counter-productive, as he would not "believe it" and think "they are just doing it because they have to do it [...] It's not, it's not spontaneous" (592-596). Also, if managers were to actively take part and/or organise regular group meetings for staff, this would be seen as a "management thing and that, it just becomes a formal gathering" (581-582), with the implication that people would not "feel free to

express themselves" (589-590). Instead, he suggested that "the support should be peer group based, for the staff [...] people should time-out together. People involved in an incident, or whatever [...] Maybe every month or something like that" (572-577).

8.2.3 Peer Support: Increasing staffing levels and teamwork

Rather than focusing on the relationship between staff and managers, 19 interviewees pointed to peer support as the most readily available source of support for staff, as well as the most effective and culturally accepted. Although the "light-hearted" and "unemotional" way in which staff tended to support and "ear bash" each other was not what everyone seemed to want or need in relation to this area of work, the importance of teamwork was repeatedly highlighted. Especially amongst healthcare and specialist staff, having the "right team" and "getting in with the team" meant feeling less isolated, as well as more effective in managing this issue, for the benefit of both prisoners and staff. For instance, Ben, Anita (specialists) and Hazel (healthcare staff), suggested that a (multi-disciplinary) team approach is "the only real practical way to manage them [individuals who are very very severely personality disordered]" (Ben, 107-108), to work consistently with people who self-harm and avoid "splitting":

> What you need to do is, and what we are beginning to do is to have a kind of multi-disciplinary approach to it. So a it's not just one person who is involved in working with that person, because it becomes too, too stressful for that one person to manage (L: yeah); but, also, a lot of the time, the person reacts with different people in different ways, so you might have splitting that's going on between staff, between psychologists, between healthcare workers. Ehm, so when everybody is all and then in the same team, and they are looking progressively at what can work, then that has some kind of meaning for the, for the client. (Anita, 146-153)

At the same time, working as a team was constructed as "sharing the burden", "looking out for each other", and, "especially in a small team", being able to "go into the office, and have a moan at something, or you can, if you feel that you are not coping, you can talk to someone else, and ask advice" (Hazel, healthcare staff, 142-144). For these reasons, "good" teamwork was not only considered to be good practice in dealing with self-harm, but also to be strongly, and causally, related to staff morale and perceptions of support:

> Because we work as a group, so:o it's not like you would feel like 'oh, I'm just stuck with this prisoner'. Because you work as a team, so everybody is there, everybody intervenes. But I think if you had to deal with them on your own, it would be really difficult here [...] And if you are not working as a team, you, you, you'll never succeed. (Fay, healthcare staff, 372-375, 653-654)

Although staff were repeatedly said to be "very supportive of each other" (particularly within "pockets" and within one's own discipline), Ian and Luke (officers) suggested that team building exercises, possibly taking place outside the context of the prison, would help staff to feel even more supported in their work. Another recurrent suggestion was to increase staffing levels. As explained by Nathan (healthcare staff), this would translate into having more "one-to-one time" with prisoners, for the benefit of both prisoners and staff:

> I'm quite sure that when there's more staff, and people that they are willing to take responsibility then we all can sort of concentrate better, and there's more one-to-one time (L: um). Which doesn't happen that often. But I would like to have more of that kind of time. Because x I can say, or show that they are much happier when you've got time and really to listen to them. Ehm, you are genuinely listening and (2) most of the time you are so busy to do this and that, unfortunately, and really it doesn't give any kind of satisfaction, for me:e or them. Because many times, when I've had that extra five minutes with somebody, that would have made quite a lot of x to somebody. And then I feel much myself because I've done something. (305-313)

8.2.4 Increasing Perceptions of "Responsibility"

Others, however, implied that having more staff and closer teams, whilst beneficial to the latter, would not necessarily bring benefits to the prisoners in their care. In Ben's (specialist) words, the "problem" lies in "engaging people to become motivated to do that job, but in a way that they see as their responsibility" (56-57).

According to Daniel (specialist), all staff need to be made more aware of current policies and procedures, whilst for Ben the key issue is "the way in which we train people up" (55). To increase and improve staff training were amongst the most common suggestions put forward by all staff groups. Overall, training was said to help staff become "a little bit more sympathetic" towards prisoners (Norma, officer, 343-344), more confident in being able to "do something about it [self-harm]" (Oscar, healthcare staff, 208), as well as more competent and effective in preventing self-harm. Particularly recurrent themes

were that staff needed a) regular (possibly yearly) "refresher courses" to avoid becoming "complacent" and b) "a bit more knowledge about self-harmers" (Nathan, healthcare staff, 357-358), "what facilities are available for these guys" (David, officer, 433-434), and more training "on how to deal with them" (Norma, officer, 520), as opposed to "how to fill in the ACCT form properly" (Nathan, 380). For some, this meant trying to understand "what's behind" self-harm (*Ibid.*, 381), which Craig (specialist) suggested might be achieved by "being lectured by some people who are regular self-harmers. And listening to them, and their reasons" (237-238). For others, learning how to manage and deal with self-harm was a perhaps more pragmatic matter, "to do - for example - with interaction, and how to approach questions, questioning that person" (Norma, 523-524). For instance, Ben (specialist) proposed for staff to be trained to adopt a "cognitive interpersonal model. Which, really, is a, is a semantic way of describing listening to people" (225-226). Further suggestions to help staff "handle them" and "the situation" were to introduce more training in mental health so that they may "identify whether it's a behavioural issues, compared to a mental health issue" (Enid, specialist, 342), and for experienced officers and nurses to "come and share their knowledge with the more junior staff" (Lee, healthcare staff, 495-496). Similarly, Catherine (healthcare staff) pointed out that training can be developed at a local level, using "the resources that are here", and, in particular, "utilizing the skills and creativity of the staff" (511-519).

Setting aside the arguably false dichotomy between understanding and managing self-harm, Luke (officer) emphasised the need for "a really good package" (714) and, like Ben (specialist), stressed the importance of training being "a process of exploration and change" (305) that staff could relate to and feel engaged with. Finally, Gail (specialist) suggested that staff also need to be taught to seek support in more assertive ways:

> So they feel that they can put forward their point of view, without having to get upset or angry, and they can just say, you know: 'this is an issue for me. I want to be away from it for the time being'. (343-345)

Whist Gail suggested that healthcare staff may be particularly resistant to admitting "that they are finding it hard" because they are "supposed to be caring, and considerate, and kind" (334-337), the data implied that officers and specialist staff may also feel the pressure to be – or appear to be – "unaffected". Amongst the former, this seemed to be linked with the "stigma attached to [...] officers who care too much" (Erik, officer, 248-

250), whilst some specialists and senior staff commented on their being "seen as somebody who (.) ought to have the experience to be able to cope with whatever comes up" (Craig, specialist, 141-142). Arguably, *all* staff groups need to learn what support is available and where, and that it is acceptable and important for them to access such provisions. However, according to Anita (specialist), "you need the Prison Service to change in its culture a little bit, before that kind of message gets across" (305-306).

8.2.5 Post-Incident Support and Supervision

The cultural pressures and resistances of which Gail and Anita (and 19 others) spoke seemed to come to the fore particularly when discussing staff's preferences for post-incident support and supervision. Although at least ten interviewees seemed to consider these a "definite good idea" (Hillary, specialist, 502), even more staff commented on their implementation being "difficult", "utopian", or even "unnecessary". For example, formal systems of post-incident support were described by all 15 officers, and all but two healthcare staff, as interventions that staff knew existed, but felt "very wary" of, and rarely used. For 14 interviewees, seeking and/or receiving this type of support were described as an "admission" of feeling "emotional", unable to cope, "weak" and incompetent. In turn, this was reflected in support being frequently constructed as an "indulgence", "pampering", "going running to people", and, above all, "having a moan". "In this sort of job" and environment, this was for many "just not the done thing" (Matthew, officer, 854-855). For instance, whilst Catherine spoke of clinical supervision as "one of the most important things" (281-282) when dealing with repetitive self-harm, and emphasised the importance of "acknowledging the fact that you yourself need help and support" (432-433), many described this as a luxury, rather than a priority, a right or a duty - and not only by virtue of the prison's "culture of bravado" (Anita, specialist, 253).

A recurrent theme amongst officers was that "nobody ever has time" or resources to either implement what may be learnt in training, "get upset" or "speak to someone". "The stresses of the job" were said to be such as to "force us that at the end of the shift you just want to go home anyway" (Ann, officer, 170-171).

Healthcare staff also commented on the (im)practicalities of being supported in this area of work, due to the "high turnover of prisoners with health problems" (Ed, 264-265) and "because there is not enough staff" (Lee, 103):

> If there is an incident and someone self-harmed, and maybe they've gone off to hospital, and some of the staff that have been involved on the wing will be told 'go home. We'll manage'. Because they are obviously upset. But because there aren't that many nurses they are just expected to go and get on with dishing out the medication and giving the injections. (Gail, specialist, 611-615)

With "80% of the [healthcare] staff" being "temporary workers", a regular system of support and supervision was said to be "difficult to have" and maintain. Even if it was possible to run an intervention of this sort (as seemed to be the case on one of the units in the prison), it was argued that bank and agency staff "tend to be a bit, a bit left out of that" (Hazel, 165-166) and, as in Fay's case, "never got a chance to go" (657-658).

Nevertheless, some suggestions were made as to how this type of support, or *elements* of it, may be useful - and practical - in this context. For instance, when working at another establishment, Gail (specialist) discussed having been involved in "a type of critical incident debrief, that was not specific to one incident, but this type of issue". In her own words:

> The feedback from the prison is that it had worked really quite well. That the staff were pleased that it had been acknowledged that it was difficult for them, and that they'd been able to talk through the emotions that (.) brought to the fore in themselves, and how they dealt with it. (156-160)

Moreover, Gail emphasised the importance of supporting members of staff who may also be self-harming, by talking "about the issues (2) what it is here to make them feel like that; what it is in the outside environment that's making them feel like that", "suggesting that they then saw the doctor, because they may need some medication", and "sending them off to counselling" (174-179).

Further suggestions were for post-incident and tertiary strategies to be more "structured" and "proactive", and to allow individuals to express any "pressures" "individually". A number of suggestions were also made as to how *group* "discussions" and supervision may be delivered, overcoming the cultural and practical obstacles discussed above. On a

pragmatic level, Norma (officer) suggested that such discussions could take place within a ten minute group meeting "of all the staff on the wing" before the ACCT reviews, "just to discuss how people are finding it (.) if the prisoners are coping with it, or how are we coping with it" (556-557). Whilst daily "hand-over" meetings were said to be taking place on every wing, these did not focus specifically on self-harm, thereby frequently failing to address these issues. A more focused meeting would also ensure that "then in the review the S.O. [Senior Officer] has got a little bit more information" (557-558) about the prisoner, which could potentially save his life. However, this would mean that the governor would have to push aside other, competing priorities, and "accept that sometimes his regime might be ten minutes late" (565).

David (officer) proposed that counselling and "regular debriefing sessions about what's going on" (373-374) could – and should – be provided to staff within the (smaller) context of a dedicated unit for self-harming prisoners. This, however, would have to be "available if staff want to talk, rather than staff having to go and talk" (377-378).

Harry (officer), on the other hand, suggested that "that kind of forum" could also take place, and "benefit" staff on the wings:

> Sit down in a circle, about 20 of you like [...] And you can get rid of lot of tension, of a lot of stress in there [...] it would be nice to have it. (L: um) it would just let everything (.) kick it out; and let you (.) vent your anger, and see what happens. I'd like that actually! {laughing} I'd love it! (631-637)

Although he also expressed concern that "you would get a lot of resistance" and would have to "fight [...] the macho image", Harry argued that with time "people will come into it, and gradually it will build up" (639-657). Indeed, this is what was said to have happened in the unit where nurses and officers did receive regular group supervision, overcoming their initial negativity. In addition, Matthew (officer) de-problematised the issue that staff may not take these discussion/supervision sessions "seriously", commenting that:

> That's probably how they (.) release it [...] the only way to deal with things sometimes is through humour [...] you take the piss out of each other, laugh about it, and then (2) get on with your job. (536-546)

8.2.6 "Dressing Things Up"

However, having already tried and failed to implement an intervention of this sort, Anita (specialist) suggested that the only chance of succeeding involves re-constructing the way in which clinical supervision is "couched" to (uniformed) staff:

> We've tried and said, you know (.) what about staff coming to de-briefs? What about having staff meetings? And, ehm, I don't know whether it's just a X {name of establishment removed} thing, and it may well be; but it's (.) there's a lot of negativity about that. Either it's because it's, it's non-uniformed staff that are offering the training or, ehm, perhaps it's just seen as, you know, you're a bit soft if you need that kind of (.) there's so, so much stigma around help, support. I think it's seen in a very negative way. So, so long as clinical supervision, is couched in a different form, then it might work. But, calling it that, would probably not work, if you see what I mean. I don't know how else you might, ehm, engineer it, {laughing} in a way! (287-295)

This solution suggests that, rather than (or, as well as) aiming for "the Prison Service to change in its culture" (*Ibid.*, 305), support provisions should aim to 'adapt' themselves to the environment in which they are to be implemented. For Catherine (healthcare staff), however, "you shouldn't have to dress things up or dress them down" (710-711).

8.3 Staff's Resistance to Support for Dealing with Repetitive Self-Harm

The data suggested that the issue was not only how staff support may be constructed - and resisted - in prisons, but also, and perhaps even more so, how self-harm is (mis)understood within this context. Whilst staff seemed generally reluctant to acknowledge needing any help or support in relation to their work, some seemed to almost resent being asked about this topic specifically with regards to repetitive self-harm. As discussed in Chapter 7, being "emotional" and "affected" by this issue were considered by many to be especially inappropriate, problematic and uncalled for, on a number of levels. Although for seven participants this meant that staff would not "admit" to needing support in relation to repetitive self-harm, for 12 others this was genuinely unnecessary, at least for oneself. Repetitive self-harm was said to be something one "mentions", rather than "discusses", and "not a big deal anymore" (Jonathan, officer, 400). Moreover, the notion of repetitive self-harm as being predictable and *not* the responsibility of staff meant, respectively, that:

> Those that (.) continuously do it, we are aware of those people [...] it's the kind of ones that you are not quite sure of, that kind of shock you more [...] I think they are the ones that you need more support. (Carol, officer, 588-596)

> I know it's not my fault that they are self-harming; I know that after they have done it (.) or, you know, or before, the different agencies, once you refer them, is all you can do. So you can't blame yourself for anything, so you don't really have to talk about it. People tend to talk about stuff that they blame themselves for doing. (Norma, officer, 482-485)

Dominant constructions of self-harm were such that staff did not only appear to resist the idea of counselling, social support, and clinical supervision - which are recurrent findings in the prison literature (see e.g. Schaufely & Peeters, 2000) - but also, and perhaps surprisingly, the notion that *they* may want or need any further training (despite this also being a common recommendation for practice).

Some of the blasé and resigned attitudes expressed in relation to repetitive self-harm and self-harmers were reflected in the recurring view that there is "no point" in training staff about this issue:

> What training can you give? You can talk to them and talk to them and talk to them. A lot of them will listen to you. But the prolific ones, forget it. Because they are doing it for 'I WANT'. (Harry, officer, 900-902)

Olivia (officer) and Nathan (healthcare staff) dismissed the need for further training on the grounds that dealing with self-harm is "quite common sense really" (Nathan, 355), whilst David and Luke (officers) commented that training is unlikely to be effective in relation to this area of work because staff did not have the resource to implement what they learnt in training, and because:

> The only way of change is if (.) the prisoners change. The prisoner behaviour changes. Ehm (.) and that won't happen. You can do all the training in the world, but if somebody's got it in their mind that people who cut themselves are weak [...] It's difficult. (Luke, officers, 696-701)

Others argued that staff *cannot* be trained to deal with self-harm, because a) "there cannot be one fixed road [...] one situation is different from another" (Lee, healthcare staff, 88); b) "you can't train someone to spot the signs. Because there are no signs" (Gavin, officer, 571-572); and c) "you can't give someone experience. They have to experience it themselves" (*Ibid.*, 474-475). According to Harry (officer):

> I don't think there's any preparing for it. The first time, it's a shock. Believe me! And you cannot prepare for that. And it's something that you get wore over you, and it's (.) panic stations [...] I don't think you can train somebody for that kind of thing, because (3) when you find it, no matter how much training you've got, no matter how much your mate is re-enacting something – your mate lying there, 'I'm cutting myself. I'm cutting myself'. There's no blood, and there's no rope around his neck, and his tongue ain't hanging out, and the eyes aren't all x (.) and when you hit it yourself, you going into (.) you go into, it's like an automatic car, you go straight into automatic. And you do what you do, and then when it's afterwards, and you go: 'oh Christ!', how did I handle that? What did I do? Did I do it right? And you've gone through it, and you don't even know you are doing it. (905-924)

8.4 Discussion

The results of this study support the previous literature in suggesting the need to support staff dealing with prisoners who self-harm (see e.g. Fillmore & Dell, 2000; Marzano & Adler, 2007; McCarthy, 2003; Towl & Forbes, 2002), as well as those who may themselves self-harm. Although this may not necessarily be perceived as essential or desirable by staff (who, indeed, seemed rather reluctant to discuss the ways in which self-harm "affected" them), their accounts suggest that such support - or at least some forms of support - not only benefits workers, but can also "contribute to the enhanced well-being of prisoners and the performance of the prison" (Liebling, Tait, et al., 2005, p. 140). For instance, many implied that, with more time and understanding, staff's reactions to self-harming prisoners would greatly improve, as well as their own job satisfaction.

Whilst the previous literature has tended to focus on individuals' thoughts and feelings about self-harm as potential causes *and* 'solutions' to negative responses, it is arguably important to understand - and address - these within their wider context. Said context may be a better focus for intervention than individual members of staff, or their cognitions, coping styles and emotions. For example, highlighting the role of organisational cultures, practices and (infra)structures may, in itself, serve to remove blame from individual employees and, in so doing, reduce many of the fears and anxieties that several staff reported experiencing. This, in turn, is not only a moral (Liebling & Arnold, 2004), practical and financial issue (e.g. in terms of reducing staff sickness and turnover levels), but a legal duty of the Prison Service.

Also continually highlighted were the difficulties of dealing with repetitive self-harm within an overcrowded and short-staffed environment. Therefore, the importance of offering staff "concrete" help with the work itself cannot be overlooked (Fillmore & Dell, 2000). Nor can one underestimate the practicalities of supporting either prisoners or staff in this difficult context. Although some implied that lack of time and resources was just an "excuse" staff used to avoid dealing with self-harm, or with the emotions it may evoke, the 'reality' of having to do so when only "six staff" are trying to "run a regime with 284 prisoners"[23] cannot be ignored (David, officer, 193). Even if this was a convenient discourse, having a system that is *not* overcrowded and under-resourced would limit the availability, and possibly the need for, such an "excuse".

Similarly, the tendency for staff to resist their own roles and responsibilities in relation to self-harm needs to be understood within the material context of their work. Whilst much of the previous literature has focused on the compatibility of the different roles prison staff are expected to undertake (e.g. Flanagan & Flanagan, 2001; Peternelj-Taylor, 2004; Towl & Forbes, 2002), it is important for research and policy to begin to consider whether *too much* is being asked of them, and whether these roles are a) realistic and b) legitimate. In other words, we need to question whether prison staff may have enough skills, resources and recognition for their complex and varied work. With much of this work taking place in an increasingly overcrowded Prison Service, and with growing numbers of mentally ill and drug dependent prisoners, it is debatable whether - in the present conditions - *all* prison staff can and should be dealing with these 'vulnerable' groups, and, perhaps more importantly, whether these should actually be in prison.

Arguably, the issue of self-harm in custody is one that interests the whole penal system, rather than just the Prison Service, and that may not be resolved until a wider (and long over-due) programme of penal reform takes place, aimed at regulating sentencing practices, and redefining the functions, (over)uses and abuses of imprisonment.

[23] In the establishment where the research was conducted the staff-to-prisoner ratio was supposed to be one to 19 (not one to 40). This, however, was said to be rare, particularly on certain locations within the prison.

Particularly in its current conditions, "prisons cannot be expected to tackle such problems single-handedly" (Loucks, 1997, p. 61) (see also Ch. 9.6).

Nevertheless, the accounts of staff suggest that, even within this difficult context, it is possible to reduce the strain of staff dealing with self-harm, and the concomitant negative attitudes. To this aim, the importance of peer support and "good" teamwork were repeatedly highlighted. Although these appeared to be mainly inter-disciplinary, there was some evidence of a shift towards more multi-disciplinary teamwork, which, indeed, is one the core elements of the new strategy to manage self-harm in custody (see HM Prison Service, 2005a). As argued by Liebling, Tait, et al. (2005), this process may be facilitated by introducing "an influx of new staff who were monitored and supported appropriately without devaluing the contribution of more experienced staff" (p. 204), and by integrating specialists through formal and informal training. The results of this study also point to the need to increase healthcare staff's perceptions of support and recognition, as these seemed particularly likely to "hold themselves separate" (Gail, specialist, 617), especially from officers. To this end, stronger leadership (see also UKCC, 1996; Freshwater, 2005) and greater attention to the needs of bank and agency staff may be recommended. Despite representing the majority of nurses working in the prison, the latter often appeared to have been excluded from formal and informal systems of support.

Whilst the main support available to staff was the informal and mainly "unemotional" help of colleagues, many spoke of the need for more support from managers - and not only in relation to this particular aspect of work. Indeed, as argued by Gail, "I don't think you can ever <u>really</u> separate these things" (121). Whilst staff were not asked directly about their views and preferences for support, *in general,* many did comment on this, in some cases even more so than they did in relation to their specific support needs with regards to prisoners' self-harm.

Above all, it appeared that staff wanted to feel valued, recognised and "involved". Similar findings have been reported by Adler (1997), Flanagan (2006), Lambert et al. (2002) and Liebling, Tait, et al. (2005), who discussed the importance of these factors for the well-being of staff, as well as prisoners. In the words of Liebling, Tait, et al.

(2005), "when staff felt valued, they were better able to care for prisoners" (p.155). Therefore, as concluded by Crawley (2004, p. 252), "the need to get staff-prisoner relationships 'right' has already been highlighted (Home Office, 1984); it is perhaps time for prison managers to get the staff-management relationships 'right' too". Prison officers' industrial action in August 2007 (see Sturcke & agencies, 2007) is one of the latest, and perhaps most powerful, reminder that there is still a lot of progress to be made in this area.

Regrettably, it is notoriously difficult to implement interventions aimed at wide organisational change, as are those targeting relationships at work, job roles and demands, and perceptions of control and support. Despite being often considered the most sensible, effective and ethically desirable area for intervention (e.g. Cox, 1993; Highley-Marchington & Cooper, 1998; Mackay et al., 2004), they can be met by strong cultural resistance, and be costly and slow to design, implement and evaluate (Parkes & Sparkes, 1998). Given the current pervasiveness of performance testing (see glossary) and (quantitative) evidence-based practice, their use and popularity may be further hindered by the difficulties in identifying easily quantifiable and measurable outcomes for such broad and complex interventions. As implied in Frank's account (see section 8.2.2), having "nothing to measure" (485) in relation to staff support can mean that nothing gets done about it.

In addition, whilst there is evidence that this type of support may improve feelings of staff well-being and job satisfaction (e.g. Garland, 2004), it is questionable whether it may necessarily bring benefits to the prisoners in their care, and, particularly, to those repeatedly harming themselves. Dominant constructions of self-harm and 'self-harmers' were such to suggest that, if staff were to have more time, resources and control over this and other areas of work, prisoners repeatedly self-harming would possibly receive *less* care and support, nor would they be considered as a priority. Arguably, no support intervention is likely to be effective unless it is part of a wider proactive strategy to counter organisational and cultural practices which label and dismiss self-injury as manipulative, attention seeking, and ultimately 'non-serious'.

It may be further suggested that interventions targeting the wider organisation need to be used in conjunction with better training, supervision and, when needed, post-incident support (Jordan et al., 2003; Rick et al., 1998). In much of the relevant literature, these are the interventions most commonly recommended in relation to self-harm (see e.g. Burrow, 1992; NICE, 2004), and in the interest of those who self-injure. These should not only target staff working directly with prisoners who self-harm, but also aim to ensure that senior staff are adequately prepared to manage, support and supervise front-line staff (Jordan et al., 2003). As argued by Rowan (1994, p. 166), "effective suicide [and self-harm] prevention training starts with the top administrator". This may help to create a "supportive" environment for staff, "an atmosphere in which people are supported to discuss events openly, learn from mistakes and receive credit for their efforts, rather than a climate of fear and blame" (Borrill et al., 2004, p. 6).

Given the above, it was rather concerning – yet not unexpected (see e.g. Liebling, Tait, et al., 2005; Marzano & Adler, 2007) – to find that most interviewees had received little or no training in how to deal with prisoner self-injury, and even less clinical supervision (see also Freshwater, 2005; UKCC, 1999). Moreover, not one of the 38 staff participants reported having contacted or having been contacted by their local care team (PICT) or the National Staff Care and Welfare Service (SCWS) (see glossary) in relation to their work with prisoners repeatedly harming themselves.

These were also the interventions most frequently and strongly resisted by interviewees. It was often implied that clinical supervision, counselling and formal post-incident support are - or would be - under-used, ineffective and impractical (see also Adler, 1997; Liebling & Price, 2001). In some cases, staff went as far as to suggest that they may be "unnecessary" or "impossible" to implement and counter-productive, "creating problems", wariness and conflict. Despite also being a common suggestion to improve practice, even the provision of formal training was described by 11 officers and healthcare staff as superfluous and futile – at least for oneself.

8.4.1 Being Supported, Feeling Supported, and Needing Support: I don't need support, but...

Contradictions of this sort were certainly not uncommon in the data. Indeed, they were possibly one of the most prevalent themes of all. Despite arguing that support was available and that current provisions were "probably enough", many reported feeling unsupported; yet not needing or wanting any support; yet they put forward a number of recommendations about this very support. Being supported, feeling supported, and needing support appeared to follow no coherent or unitary path, especially when the word "support" was used. The use of this term - which may be confused with "social support" - may have led to staff feeling reluctant to acknowledge the need for some (practical or emotional) help or input, more so than a more neutral and 'macho-friendly' term. For example, staff seemed to respond better to the idea of a discussion meeting, than that of a support group (fieldwork notes).

In the context of what remains a "predominantly macho culture" (Snow & McHugh, 2002, p. 151), supporting staff, or even discussing issues around support (see also Ch. 2.2 and 2.10.1), present considerable tensions and challenges (see also Borrill et al., 2004; Liebling & Price, 2001). As argued by Connell (1995), amongst others (e.g. Lee & Owens, 2002; Lupton, 1998), to be expressive and truthful about one's feelings, and to seek support, conflict with notions of hegemonic masculinity. In a (male) gendered institution (Carrabine & Longhurst, 1998), these "emotion display rules" (Crawley, 2004) can affect both male and female members of staff (see e.g. Britton, 1997; Zupan, 1986). Indeed, participants of both genders tended to construct being emotional (particularly in relation to prisoners' self-harm - see also Ch. 7.4.1) as being "too emotional", "weak" and "annoying". As a result, and regardless of what interventions may actually be in place to support workers, "the problem is [also] getting staff involved" (Daniel, specialist, 72-73):

> Actually getting the officers in, is the thing [...] you will fight the macho image all along with screws[24]. (Harry, officer, 620, 925-926)

It is therefore important to trace these resistances, as they may affect how staff discuss this topic, as well as their readiness to use different types of interventions, and the

[24] In prison slang, the term "screws" is used to denote prison officers.

benefits they – as well as prisoners – may derive from them. Exploring participants' "ideological dilemmas" (Billig et al., 1988) about the very notion of support, and about different types of support, offered useful ways of highlighting, interpreting and negotiating some of these tensions and contradictions. Acknowledging these dilemmas, rather than trying to 'smooth them over', revealed that staff may not be as negative about receiving support as may first appear, and that this may not be as "impossible" as some implied.

For instance, and despite staff being often negative about formal systems of post-incident support, three interviewees commented that, at a psychological and symbolic level, the availability of such services "is a good thing", regardless of whether staff actually utilise them. Others also argued that their very existence indicates that prison staff must use and benefit from these interventions much more than they are prepared to admit. This, in turn, implies that negative comments should not serve as a basis to suggest removing or downsizing the PICT, which was already struggling with problems of low numbers and poor recruitment, and whose members appeared to receive little support or recognition for their voluntary and unpaid efforts. Nor should they be used to bring further cuts to the SCWS, which at the time of the research had only 16 staff members working in 139 establishments (with little administrative support), and whose future was already said to hold in the balance. Plans to "have no [SCWS] personnel in any of the prisons", leaving it "all down to the senior officers and the principal officers to manage <u>their staff</u>", together with the prospect of "self-generating sick letters" and telephone counselling (Gail, specialist, 412-415) (for further discussion see Finn, 1998; Highley-Marchington & Cooper, 1998), were criticised as short-sighted, and *not* cost-effective, and said to lead to senior staff having no discretion, and wing staff feeling increasingly resentful. As highlighted in the literature, whilst it is crucial for managers to be supportive, it is also important for clinical and managerial supervision to remain distinct (see e.g. Chantler et al., 2001).

In addition, and despite the resistance of some staff, the data suggested that regular group support and supervision for staff from all disciplines (rather than only healthcare staff) may be useful and effective, *if* delivered and couched in certain ways. Arguably, removing the label 'clinical' before the word supervision may be an important first step

towards the delivery – and acceptance – of supervision and reflective practice amongst staff who do not have a medical role. More generally, it has been suggested that the very term supervision can be misinterpreted by staff to mean "appraisal" (Borrill, personal conversation, 6th September 2004), and that this may lead to further resistance.

Therefore, it is tempting to conclude that, along with some of the wider interventions suggested by participants (most notably, increasing staffing levels and involvement in decision-making), *all* staff should receive regular training and supervision, and be encouraged to reflect on their own personal and professional reactions to self-harm. In addition, if and when necessary, staff ought to receive further counselling and support to help them deal with this complex area of work. Consistent with participants' suggestions, the latter type of support should be proactive, voluntary and independent. Furthermore, all of these interventions should be better "publicised", along with the importance and legitimacy for staff to seek and receive support following an incident of non-suicidal self-harm.

8.4.2 'Ideal' versus Pragmatic Recommendations

However, one cannot ignore that, on the whole, prison staff, and especially officers, were seemingly resistant to the principles of reflective practice, emotional support and "trauma disclosure" (Clarke, 2004). It is arguably problematic to recommend strategies that are in conflict with staff's express wishes and suggestions, particularly as there is little evidence to substantiate claims of their effectiveness (see Edwards et al., 2005; Stevenson & Jackson, 2000), and some suggestions that they may actually be counter-productive (e.g. Clarke, 2004; Holdsworth et al., 2001). To do so would appear to negate the very notion of user-led, "bottom-up" research and practice that informed the current study.

On the other hand, it is important to remain mindful of the broader implications of these interventions, including their effects for the wider organisation, and, above all, for prisoners who repeatedly injure themselves. It may be suggested that the needs of the latter should also be taken into account when considering strategies to support staff, and that the effects of any intervention should *also* be evaluated in relation to prisoner care and well-being.

Previous studies have suggested (or at least implied) an overlap between the factors contributing to staff well-being and satisfaction, and those influencing patient/prisoner care and welfare (e.g. Finn, 1998; Liebling, Tait, et al, 2005). However, the findings of this study suggest a rather more complex, and less rosy, picture. What appeared to be "functional" – yet possibly maladaptive – for staff did not coincide with what may be helpful for prisoners. In particular, what seemed to help staff cope with this area of work was to deny and/or minimise their responsibilities towards self-harming prisoners, most notably by constructing this behaviour as something outside of their competency (whatever that might be), and avoiding further training which may bring on more responsibilities in this area (see Ch. 7.3). As argued by Yegdich (1998) in relation to clinical supervision, one must consider that the "sentimental blurring" of personal and professional support can obscure the "more subtle issue of patients' rights" (p. 197).

Ideally, interventions should aim to balance the needs of staff and prisoners, and be aware of the potential mismatch between the personal and professional needs of staff. Regrettably, however, some participants implied that existing provisions were neither targeted at their own welfare, nor at that of prisoners. Rather, the financial and actuarial needs of the organisation seemed to be shaping the current and future design and delivery of services in ways that may bring limited benefits to either staff or prisoners. Despite the repeated suggestion that staff support had improved in recent years (indeed, when some participants had begun working in prisons there were *no* formal systems of support available), and that there is now "more of the culture of care" (Anita, specialist, 110), the data indicated that the situation may again worsen over the coming years. For example, the move (or willingness to move) towards a specialist wing and/or workforce (see also HM Prison Service & Department of Health, 2006) to deal with "poor copers" means that resources are and will be targeted towards 'at risk' prisoners and staff. Whilst it is not necessarily problematic for some staff to receive more in-depth training on self-harm, it arguably becomes so if it means that others end up receiving little or no training at all. As stated by Matthew (officer):

> You'd have to support everybody, because during, during the day, everybody will have some interaction with an inmate who self-harms. Everyone that works on the wings, or somewhere like here (.) ehm, they are going to come into, into interaction with them. (760-762)

Recommending that *all* staff should receive regular support and supervision in relation to prisoner self-harm is not only potentially in conflict with the express wishes of staff themselves, but also with the 'realities' of an overcrowded and under-resourced Prison Service. This, in turn, creates a tension between proposing an 'ideal' broad, proactive, holistic strategy and a perhaps more pragmatic and focused approach. In the current UK context, the former may be linked with what Carlen (2007) refers to as "imaginary penalty", whereby "in order to keep their jobs, personnel [...] are required by the terms of their employment to act 'as if' the imaginary is both attainable and measurable while, at the same time (*and in order to keep their sanity and self-respect*) they must also insist that they can hardly be expected" to do so (p 11; emphasis in original). Advocating for all staff to be regularly supported and supervised risks becoming just another example of imaginary penalty: a pervasive promise in official rhetoric, but, as argued by many participants, unimplemented and simply unfeasible.

On the other hand, the adoption of a more focused and cheaper 'solution' may justify and bring further legitimacy to practices and discourses that, in the long run, may be counter-productive. For instance, one suggestion for achievable staff *and* prisoner support was to place all self-harmers on a "high dependency unit". Arguably, this approach reinforces the conceptualisation of self-harm as a problem that may be confined to a designated unit and diagnosed *in* individuals through improved screening at reception. This, in turn, ignores the role of the organisation in creating self-harm, and the possibility that individuals may *become* self-harmers in prison, because of problems inherent in the environment, rather than themselves. Regardless of - or perhaps in view of - prisoners' "imported vulnerability" (see Liebling, Durie, et al., 2005), the "pains" (Sykes, 1958) and effects of imprisonment (see Cohen & Taylor, 1972; Liebling & Maruna, 2005; Sykes, 1958; Toch, 1992b; Zamble & Porporino, 1988) cannot be overlooked. At the same time, this strategy may offer a (short-term) 'solution' to prisoner self-harm and, in so doing, continue to legitimate the (over)use of imprisonment for people with complex mental health *and* socio-economic needs who have committed minor offences (see Carlen & Tombs, 2006).

A similar point can be raised in relation to the suggestion to make support services more appealing to staff. For instance, whilst it may be tempting to "dress things up or dress them down" (see section 8.2.6) and couch support interventions in more 'macho-friendly' ways in order to attract more (uniformed) staff, "perhaps this would miss the point" (de Souza & Ciclitira, 2005, p. 803). "A more beneficial approach might be one whereby discourses and practices of masculinity are exposed and challenged rather than simply manipulated and perpetuated" (*Ibid.*).

Arguably, one 'solution' that continues to receive too little consideration is that all staff should benefit from a comprehensive stress management strategy, in the context of a much less crowded Prison Service, used as punishment for only the most serious offenders.

8.5 Conclusions

The accounts of staff revealed a number of tensions and inconsistencies relating to their work with prisoners who self-harm. Not only did there appear to be a gap between the demands placed on staff by repetitive self-harm and the resources available to them to deal with this issue, but also between the help available to staff, and their support preferences. Possibly with the exception of peer support, questions were raised about the adequacy, availability, and effectiveness of current support interventions. This imbalance between ideal and actual support seemed to be further complicated by a mismatch between what support staff might want and need and, perhaps more importantly, between what may benefit them and what may instead help prisoners.

Supporting staff may help to improve their reactions to prisoners who self-harm, but this process is certainly not straightforward. Nonetheless, it is possible. This chapter has focused on how the difficulties and resistances so often documented in the previous literature may be overcome in practice, and considered the feasibility and potential dangers of different 'solutions' suggested by staff. Whilst it would be infeasible to suggest a single, clear solution to such complex issues, it does seem plausible to conclude that for any of these to 'work' and be taken seriously, it is important that self-harm and the effects it may have on *all* staff are no longer under-estimated or "forgotten". In the words of Anita (specialist):

A lot of the time we under-estimate the impact that working with this client group has on us, and a lot of the time, because we don't pay enough attention to looking at the clinical supervision aspects of it, the (.) it gives rise to (.) blaming, ehm, labelling, punitive behaviour. Because when you don't understand someone's behaviour, or are feeling stressed out by it, we are more likely to react to it in a negative way. So if you are talking about promoting good practice, with the self-harmers, you need to promote good practice with the people working with self-harm. Because you can't have one without the other. So I think that your research, looking at what the issues might be, for practitioners is really really worthwhile, and that would be the one thing to stress: is that there needs to be enough of a looking after of the people working with self-harm, as well as the self-harmers themselves. (327-336)

Chapter 9. General Discussion and Conclusions

Breaking away from the positivist tradition that had dominated much of the previous literature in this area, this study has drawn on a critical phenomenological perspective, to explore the issue of self-harm in men's prisons. Rather than aiming to identify 'risk factors' or to predict who may be more likely to self-harm (or to respond to self-harm in negative ways), its focus has been on the different meanings and implications that this phenomenon may have for prisoners and staff. In the words of Wexler (2006, p. 2940), "it is this process of meaning making that situates people's parameters for action", or - as often seemed to be the case in relation to staff - of *non* action.

Considering this phenomenon from multiple and reciprocal perspectives has added depth and breadth to our understanding of non-suicidal self-harm in custody. Nevertheless, this picture remains fragmented, situated and contested. Consistent with previous studies (see e.g. McAllister, 2003a; Rayner & Warner, 2003; Turp, 2002), this research suggests that self-harm is a complex and multi-faceted issue, that does not lend itself to a single explanation or definition nor to simple solutions. Indeed, institutional solutions may not always even be desirable.

In much of the relevant policy and literature this has tended to be constructed as problematic, on theoretical, methodological and practical grounds. For instance, the availability of multiple and broad definitions of self-harm has been said to "blur the distinctions between behaviours that may have clearly distinct motivations and functions for individuals" (Crighton & Towl, 2002, p. 51), and to have "the practical effect of making comparisons across studies difficult" (*ibid.*, p. 64). In research, this appears to have been associated with attempts to 'smooth out' the "messiness" (Law, 2005) of this phenomenon, by imposing rigid, hierarchical and arguably artificial distinctions between behaviours, groups and motivations (e.g. Klonsky, 2007; Snow, 2002a).

However, from a post-structural feminist perspective, the recognition of multiple versions or constructions of 'truth' in relation to self-harm has been described as potentially liberating and empowering (e.g. Shaw, 2002; see also Bordo, 1993). It may

help to challenge dominant and often stigmatising understandings of this issue, and encourage more flexible responses to people who self-harm. In the words of McAllister (2003a, p. 184), "opening up self-harm to multiple readings offers hope that individualised, effective responses for clients may be possible".

"Self-harm is not a phenomenon that can be readily identified and circumscribed" (Turp, 2002, p. 213); to attempt to do so may be "impracticable" (Rayner & Warner, 2003) and potentially counterproductive. With this in mind, the following section summarises the findings of the current research, whilst trying to portray, and celebrate, their complexity, and to minimise the generalisations that are perhaps inherent in this very task. The main themes that have emerged in individual chapters are thus drawn together and discussed in relation to the broader literature, and to the ways in which they were 'produced'. As argued in Chapter 2, research findings and interpretations cannot, nor should they be isolated from one's methods and standpoints (Harding, 1991). Following consideration of some of the ethical concerns raised by these very methods and standpoints, the chapter concludes with recommendations for future research and political practice.

9.1 Staff's and Prisoners' Constructions of Non-Suicidal Self-Harm

The results of this study suggest that even when acknowledging the "many faces of self-harm" (Turp, 2002) things are rather more complex than would first appear. In explaining, justifying, and/or condemning self-harm, staff and prisoners drew on a variety of discourses and themes. In virtually all cases, participants seemed to portray different 'truths' about self-harm, and its multiple origins, functions and meanings. However, in the accounts of many staff this did not seem to be associated with more empowering, flexible or "effective responses for clients" (McAllister, 2003a, p. 184). Quite the contrary, when pointing to the complexity of self-harm and the many forms it may take, staff tended to construct these differences in a rigid and hierarchical manner, positioning different categories of 'self-harmers' as being more or less "real" or "serious" (see also Batsleer et al., 2003; Chantler et al., 2001; Spandler, 1996). Similarly rigid were the boundaries between what staff seemed to consider 'normal' behaviour and self-harm, with only one member of staff suggesting the possibility of some overlap between the two (for a critique see Turp, 2002). Thus, whilst some types of self-harmers

were constructed as being more deserving of care and help, they all tended to be "Other" (Maccallum, 2002; see also Ch. 5.1.1).

In view of the priority given to suicides in custody, it was perhaps unsurprising to find that (seemingly) non-suicidal forms of self-harm tended to be at the bottom of this hierarchy (see also Pannell et al., 2003; Snow, 1997). What was arguably more concerning was that suicidal and non-suicidal 'self-harmers', and different types of self-harmers more generally, were considered by most to be "completely different things" (Harry, officer, 147-148). Whilst prisoners had also drawn a distinction between suicidal and non-suicidal intentions, they often suggested that one's motivations for self-harming could be multiple, ambivalent and shifting. Whether or not suicide and self-harm may be separate phenomena (see Ch. 1.1), it was clear from their accounts that suicidal and non-suicidal self-harmers were not necessarily two separate groups (see also Dear et al., 2000), nor were the "poor copers", "attention seekers", "mentally ill" and "drug users".

What was also perhaps expected was that prisoners' whose self-harm was "prolific", and not seemingly motivated by suicidal intent, tended to be perceived especially negatively by staff and, again, in very rigid manner. This has been well documented in the UK and international literature, both in prisons and outside. In turn, this finding, and evidence that different forms of self-harm are *not* mutually exclusive raise doubts over the viability and desirability of reinforcing this (artificial) notion by making it the object of research. To (inadvertently) suggest that repetitive forms of self-harm are any different from more sporadic forms may also reinforce negative staff practices, including that of becoming "complacent when assessing motivations, jumping to conclusions rather than looking at each new incident with fresh eyes" (Fagin, 2006, pp. 197-198; see also NICE, 2004).

Moreover, to focus one's research specifically on repetitive forms of self-harm may result in portraying a particularly negative picture of staff (or more negative than if other forms of self-harm had been considered), in what had already been selected as an establishment facing particular challenges in this field. Staff at an over-crowded local prison (such as the one where research was conducted) tend to have "more limited opportunities [...] to form relationships with prisoners" (Howard League, 2001, p. 4; see

also Ch. 2.5). This, and the low morale of which many spoke, meant that participants in this study may have been more likely to express negative views about self-harmers than staff dealing with a less transient population, in a smaller and better resourced establishment.

Despite these reservations, it was arguably important to explore the different meanings and implications that self-harm may have for both prisoners and staff, separately from the issue of attempted suicide. Non-suicidal forms of self-injury have long been eclipsed by the priority given to suicides in custody, in turn perpetuating the notion that they may be less serious. Furthermore, their being addressed, or more often "buried" (Howard League, 1999), within the same (suicide) preventative framework has meant ruling out, a priori, the possibility of *not* trying to prevent (all) self-harm at all costs (see also Rickford & Edgar, 2005). As argued later in this chapter, this approach can be counter-productive for both prisoners and staff, and ignores that some forms of self-harm may be a meaningful (if maladaptive) coping strategy (see e.g. Harker-Longton & Fish, 2002; Shaw, 2002).

It was therefore useful to ask staff to comment specifically on repetitive, non-suicidal self-harm, particularly as many seemed to consider this to be a separate, and especially negative, phenomenon. Indeed, with hindsight, it would have been useful to further explore with participants how they defined a "repetitive self-harmer". Whilst interviewees were asked how they constructed the notion of self-harm, in general, the point at which a "self-harmer" came to be seen as a "prolific self-harmer" was often unclear. Although it would be unfeasible (and potentially dangerous) to suggest otherwise, exploring these (blurred) boundaries may help to further deconstruct negative reactions, and to assess the feasibility of developing "different strategies [...] for those who attempt suicide and those who injure themselves for other reasons" (Snow, 2002a, p. 25). For instance, Carol (officer) suggested that "repetitive self-harmers [...] need necessary support, ongoing". To this end, and for staff to know when to call upon such support, it may be useful to define:

> How often would they need to perform the act to be defined as repetitive? [...] How often would they have to self-harm for us to refer them to somebody to come in and (.) that's, that's the hardest bit really to define. Ehm, and therefore have the necessary support available. Yeah, so how

> many acts would define that? Over how long a period of time? You know, we're not really given that information. So that's the hardest bit. (420-425)

Despite this potential limitation, most staff spoke at length of their views and experiences of repetitive self-harm, and, more often, of repetitive *self-harmers*. Unlike most previous studies, this research aimed to deconstruct and contextualise their (mainly negative) reactions, whilst tracing the more positive ways in which workers may respond to this issue (or better, how the organisation may encourage better responses to self-harm).

As in previous studies, the notion that prisoners who repeatedly self-harm are "attention seekers" was a recurrent theme, particularly amongst officers and healthcare staff. In turn, this was open to a number of readings, and situated within multiple, and at times overlapping, discourses. In some cases, "seeking attention" was conceptualised as being ("just") a "cry for help". More often, it was constructed as a rational, calculated and "manipulative" action, or "threat" of action, and became almost synonymous with drugs and/or medication seeking. Either way, prisoners' motivations for self-harming were often described as neither "serious" nor "real", arguably overlooking and trivialising their experiences and distress, as well as staff's own role in precipitating or indeed managing self-harm.

These claims were frequently contradicted, particularly in the accounts of (some) specialists, and those of prisoners themselves. Both groups brought attention to the men's difficult backgrounds and circumstances, and to the emotions (rather than the "demands") behind their self-harm, *and* their being "poor copers", "drug users" and "PDs". In so doing, they positioned self-harmers within a 'victim' and/or 'survivor' discourse, whilst reframing their behaviour as a desperate, but meaningful, coping strategy. To this extent, these accounts do not only challenge the opinions of many staff members, but also the interpretations of the (scant) literature on male prisoner self-harm (e.g. Rivlin, 2006, Snow, 2002a, WHO, 2000).

9.2 Privileging Gender?

Locating these findings within feminist, gender-aware perspectives offered useful ways to highlight how dominant discourses around masculinities may influence current understandings of self-harm. Naming male self-harmers as men (Hanmer, 1990) helped to challenge some of the negative stereotypes about male self-harm being mostly "violent" and "instrumental" (e.g. Power & Spencer, 1987; Rivlin, 2006; Snow, 2002a). To this extent, privileging gender was actually useful in suggesting that gender should not necessarily be privileged in discussions around self-harm, particularly if this may result in obscuring issues of class, 'race' and sexuality (to mention a few), and their complex intersections. Constructing one's analysis in terms of power and power relations is arguably more productive than to focus on unitary notions of 'man' or 'woman' (see also Ch. 6.1.6).

This, however, is not to suggest that gender should be excluded or overlooked in relation to self-harm. Indeed, applying a feminist analysis to the study of male self-harm served as a useful reminder of how important it is to deconstruct dominant discourses around gender and masculinity, as well as around self-harm. As suggested by Bowen and John (2001, p. 367) "negative masculine constructs" may influence how behaviour is understood and constructed. Indeed, some of the feminist re-framings and discourses that have been shown to be associated with more positive responses to women who self-harm, seemed to have the opposite effect where men were concerned – possibly also by virtue of their being prisoners (see Ch. 5.5.1).

Moreover, the accounts of staff suggest that the myth of self-harm as a "female disorder" (Shaw, 2002) remains dominant, arguably to the detriment of both women and men. With hindsight, it would have been useful to explore its effects more directly, for example by asking prisoners about the tensions, if any, of "being a bloke" (Elliot, n.d.) and a "self-harmer". Nevertheless, as "feminized deviant others" (Brickman, 2004, p. 106), the accounts of male prisoners may not provide as powerful a critique to this discourse than those of groups seen as less "primitive" or "abnormal" (*Ibid.*), as may be White, middle class, non-criminal men. Even if relatively rare (which in itself is disputable – see Taylor, 2003a), their voices also need to be heard.

9.2.1 Masculinities in Prison and Gendered Readings of Staff's Responses to Repetitive, Non-Suicidal Self-Harm

Theories of masculinities also offered a useful framework within which to interpret and conceptualise the responses of staff (and different groups of staff) to self-harm, and their (un)willingness to seek support in relation to this issue. Indeed, it is perhaps surprising that these have not been granted greater consideration in previous accounts of these topics. Firstly, as stated above, self-harm has been traditionally constructed as a (female) gendered issue, and prisons (especially male prisons) as "hyper-masculine" "gendered organisations". Whilst clearly not the only influence on staff's reactions to self-harm (and their accounts of such responses), discourses of masculinities are likely to be embedded in the daily practice of how prisoners and staff respond to, and cope with, each other (or an 'outsider' such as myself). As discussed in Chapters 4(.8) and 8 (see especially 8.3 and 8.4.1), to express "sympathy for the prisoner" (Crawley, 2004) and to appear "emotional" about this aspect of one's work, may conflict with the occupational norms of prison staff – if for different reasons.

Being (and being expected to be) caring, "hardened" and "able to cope with whatever comes up" appeared to raise a number of tensions and anxieties for all staff interviewees, but perhaps especially for healthcare staff, officers and specialists, respectively. Clearly, the "patterns of masculinity" (Hsu, 2005, p. 1) in prisons have different implications for different staff groups (and, undoubtedly, different individuals and situational encounters). Whilst there was insufficient data to develop these themes in relation to specialists (see section 9.5.1), these findings lend support to the notion that officers and healthcare staff (especially nurses) embody historical constructions of masculinities and femininities (see e.g. Davies, 2003). Exploring these constructions may therefore add to our understanding of the complex - and frequently fraught - relations between these two staff groups.

Again, this may be especially the case with regards to this particular aspect of their work. The "perennial issue of care versus control" (Sim, 2002, p. 315) - which this and previous studies suggest to be central to staff's responses to prisoners who self-harm (and those who do not) - appears to reflect a gendered debate, and is indeed reminiscent of the notorious exchange between Kohlberg (1975) and Gilligan (1982) over gendered

ethics and morality (see Capdevila, Ciclitira, Lazard, & Marzano, 2005; Peter & Morgan, 2001; Sharpe, 1992). For reasons of central focus and word count limits these themes could not be fully developed in this thesis, but they arguably warrant further consideration.

As discussed in the previous section with regards to prisoners, it is important that this attention to gendered practices, discourses and occupations does not come at the expense of other factors of potential relevance. The 'racial' differences between the sample of (predominantly 'White') officers and (mainly 'Black') healthcare staff taking part in this study seem particularly worthy of further consideration. According to Gareth (healthcare staff), this was representative of the ethnic make up of officers and nurses working at the prison, and further exacerbated the "culture clash" between them:

> I'm sorry to say that, but I think the, the morale is so low in here, because, ehm, ehm, I should say 90% of the people, nurses in this place are ethnic, of, of ethnic origin. And basically most of them, there seems to be quite a lot cultural, language barriers. (L: right) you know. Because what happens is 90% of the officers are mainstream officers, White English officers. ..hh and, ehm, the nurses themselves don't seem to understand that there is a need for any security, you know, procedures to be taking place. And x cultural, professionals, culture, the whole lot. (40-46)

The finding that most healthcare staff at the prison were temporary workers (unlike officers) suggests an additional dimension of difference - and potential "Otherness" (Wilkinson & Kitzinger, 1996) - between nurses and officers, requiring some attention. Exploring the intersectionality of issues of gender, 'race' and occupational status (amongst others) in relation to these staff groups may also offer useful ways of conceptualising their relationships with each other, and with prisoners. In turn, this may help to better comprehend and address the needs of all involved.

9.3 Bridging Staff's and Prisoners' Accounts

The finding that people who self-harm construct their behaviour differently – and more positively – than workers and 'carers' is certainly not new (e.g. Harris, 2000; Loucks, 1997; Reece, 2005), nor perhaps surprising. Indeed, according to McAllister (2001), this is the "standard story" about "the weak and vulnerable being dominated by the arrogant and insensitive professionals" (p. 393). On the other hand, and especially within the

nursing literature, these same findings may be seen to reinforce the "tribal story" of the caring and overstretched professional being controlled and manipulated by the bad and demanding prisoners (Cooper, 2001). Either way, the rigid, binary thinking underlying these stories "risks oversimplifying complexity" (McAllister, 2001, p. 393) and may (negatively) "influence the care that is given" (Cooper, 2001, p. 35). In addition, it arguably strengthens a false and forced dichotomy between prisoners and (different groups of) staff, and, in so doing, detracts attention from the systems which (re)produce and constrain the experiences and actions of both.

As argued in Chapter 3, it is important that the views and reactions of staff (as well as those of prisoners) are understood within a systemic and relational framework. This may not only serve to remove blame from individuals, but can arguably offer greater possibilities for change than the view that staff are inherently 'bad' and uncaring, or that self-harmers are an inherently "difficult" and "challenging" group with whom to work. Moreover, locating these responses within their wider contexts revealed some interesting parallels and similarities between the accounts, experiences and difficulties of staff and those of prisoners.

Although the prisoners were critical of how staff responded (or failed to respond) to their self-harm, and their needs more generally, their accounts suggest that they were aware – and, in some cases, understanding – of the difficulties of staff. Like staff themselves, they believed these to be related, at least in part, to negative reactions and practices. Thus, concurring with Adler (1997), staff and prisoners were not two battling groups. Indeed, like prisoners, some staff were uneasy with their colleagues' uncaring approaches, and (but less often) with their own inability to fulfil a caring role. In many cases, inter-staff and staff-management relationships were as difficult and complex as those between staff and prisoners (see also Crawley, 2004).

When discussing staff's negative responses to self-harm, both staff and prisoners pointed to the inadequacies of a system that is ill-prepared to deal with the complex needs of prisoners, or indeed of staff. Even though many seemed reluctant to acknowledge or discuss being "affected" by prisoners' self-harm, the majority of staff commented that dealing with this issue was challenging and frustrating and that they did not have the

practical resources and/or skills to deal with it (see Ch. 7). Also implicit in many accounts were the contention that staff felt unsupported in relation to this area of work (and more generally) and had little or no control over it. Even when staff seemed to consider self-harmers to be an inherently difficult and "annoying" prisoner/patient group, it was clear from their accounts that these constructions could not be isolated from their roles and responsibilities in this area of practice, and the difficulties associated with them - especially in such under-resourced and overcrowded environment. These tensions (including those created by the prison's patterns of masculinities - see section 9.2.1) did not only manifest themselves in workers' responses to (different types of) self-harm and self-harmers, but also in how they constructed and responded to their own needs and emotional reactions to this issue. Thus, some of the practical and cultural barriers that appeared to prevent prisoners from being adequately supported in relation to their self-harm also seemed to hinder perceptions of support amongst staff.

9.4 Beyond Self-Harm and Staff-Prisoners Dichotomies

This study suggests that both prisoners' self-harm, and staff's negative responses to it, are not necessarily *the* problem to be addressed, but are more usefully conceptualised as a symptom of wider stress, distress and helplessness. This was also reflected in staff's and prisoners' preferences for support. Both groups commented that the help they required was not necessarily nor exclusively targeted at this particular area, but should aim to generally enhance their life, or work, in prison. Indeed, policies and procedures specifically focused on self-harm were often constructed as potentially counterproductive, particularly when their aim was, or was interpreted to be, that of "stopping" self-harm. This does not only reinforce the notion of self-harm as the behaviour (or problem) to be managed and prevented, but also seemed to be associated with a variety of bureaucratic and defensive practices (see also Inch et al., 1995) that both prisoners and staff considered unhelpful and possibly "unrealistic". As discussed in Chapter 7, staff often felt unable to stop prisoners from self-harming, and considered this to be one of the worst aspects of this work. In this context, the repeatedness of "prolific" forms of self-harm (even regardless of prisoners' presumed suicidal intentions) may lead to staff feeling especially helpless in dealing with - and trying to stop - this behaviour (see Ch. 7.4.1).

Also, the actuarial conceptualisation of "care" permeating current policy (see also Rickford & Edgar, 2005) seemed not to coincide with what prisoners considered to be a caring response. Many expressed dissatisfaction about the de-humanising methods used to try and stop them from self-harming (see also Kilty, 2006; Power et al., 1997), and in three cases commented on their not wanting to stop. Rather than self-harming to "get themselves on ACCT" (Bernie, officer, 132), some equated this with being "watched", reduced to being "just a piece of paper", left unable to work and kept awake at night by staff's constant checking on them. This suggests that, as well as redefining what the notion of - and obligation to - care may mean and involve for staff (especially healthcare staff - see Ch. 7.4), it is important to consider how its supposed recipients construct and envision discourses and practices of care. Doing so is not only useful in terms of developing user-led policies (see section 9.6.4), but may also help to prevent or reduce feelings of helplessness, embitterment and disappointment at not being treated in ways that are perceived to be fair and "expected" (see also Ch. 6.2.3). As discussed in Chapters 5 and 6, these reactions can "carry a more profound hurt" (Sykes, 158, p. 78; see also Porporino & Zamble, 1984), becoming a cause of further and potentially more severe self-injury (see e.g. Haycock, 1989; Ivanoff & Jong, 1991; Williams & Pollock, 2000; Williams, 1997). Beyond self-harm, these feelings may be associated with problems of "security", "order" and "control", in custody and upon release. "If prisoners are released in an embittered and disaffected state then the criminal justice objective of preventing re-offending is undone" (Woolf, 1991, para. 14.8-9).

Bringing attention to the "sick system" involved in the production of self-harm, and of staff's negative reactions to it, is not, however, intended to de-problematise either of these issues. Whilst possibly seeking to de-pathologise them, their normalisation may silence and trivialise the needs and distress of which both speak, as well as overlooking their potential implications. Even when prisoners may not self-harm with suicidal intent, their behaviour, and the reactions of staff, may well have fatal consequences. To construct either of these as being meaningful and rational (or at least doing so without fully considering their context) also risks overlooking wider issues of abuse, neglect and powerlessness, and the other forms in which they may manifest themselves, including drugs and mental health problems. The finding that staff were frequently unsympathetic

towards "drug users" and "PDs" - regardless of their self-harm - is as concerning as evidence of prisoners' poor treatment in relation to self-injury.

In addition, and whilst it is important to avoid reinforcing rigid dichotomies between staff and prisoners, the differences - and power differentials - between these groups cannot be overlooked. Although their behaviours and practices may reflect some similarities in circumstances, the ways in which these were negotiated were not necessarily similar, nor did they have the same outcomes. As discussed in Chapter 8, what seemed to be "functional" (yet possibly maladaptive) for staff did not always coincide with what was helpful for prisoners. Therefore, whilst unsupported and "distressed prison staff are less able to empathise with prisoners and provide at-risk prisoners with support" (Liebling, Tait, et al., 2005, p. 140), the data suggested that supported and satisfied staff would not necessarily be more caring, nor would this necessarily benefit prisoners. 'Solutions' that may have a positive result for all concerned are unlikely to be simple or one-dimensional.

9.5 Deconstructing One's Deconstructions: Contextualising research findings and interpretations

Before moving on to consider whether it is even possible or desirable to suggest some solutions, it is useful to reflect further on how these findings were produced. Every stage of this research has been influenced by a number of ontological, epistemological, political and pragmatic considerations, in turn shaping its outcomes and interpretations. The following section considers some of the implications and limitations of this study's praxis (for a more detailed discussion see Ch. 2).

9.5.1 Shifting the Gaze to Staff ... Or Looking Away From Prisoners?

'Shifting the gaze' to staff, and their own views and experiences of this phenomenon, was partly intended to divert attention and blame away from prisoners who self-harm, and onto the negative responses and practices that may contribute to create and "regulate" (Groves, 2004) this phenomenon. However, it is important to consider whether doing so may have actually ended up detracting from the stories of prisoners, whose voices also need to be heard (see e.g. Kilty, 2006; Thomas et al., 2006).

The decision to include the views of staff from different disciplines and grades meant having to re-scale the study with prisoners, limiting the amount of data I was able to analyse or write up as part of this thesis. Rich, qualitative data pertaining to the life histories and coping strategies of the 20 men interviewed could not be discussed in great depth, to avoid excessively broadening the focus of the thesis, or exceeding the imposed word limit. However, as argued in Chapter 1, it is important, theoretically, to explore the men's experiences beyond prison. The ethics of failing to incorporate these data also need to be considered, especially given their sensitivity (Renzetti & Lee, 1993), and how difficult it may have been for interviewees to discuss these issues. Nevertheless, their personal narratives are inevitably reflected in the accounts produced, and will provide valuable material for future research outputs.

In any case, it was worth incorporating the views of different staff groups. Indeed, it was the prisoners who pointed to the importance of interviewing nurses, doctors and (some) specialists. Doing so provided information about groups whose needs and concerns are often overlooked in policy and research, despite their involvement in the care and regulation of self-harm in custody. With hindsight, it would have been useful to elicit more information about specialists' own experiences and difficulties in dealing with this area work. Given their roles with other staff (as well as prisoners), the latter were mainly asked about their opinions of the impact of self-harm on officers and healthcare staff. In view of their very specific, identifiable and heterogeneous roles within the establishment, it may have been problematic to try and portray a picture of their experiences of this area of work, whether these were considered as a group or individually. Nevertheless, collecting more data about their - often more positive - constructions of self-harm, and their ways of coping with such issue, may have lead to a better understanding of the sorts of discourses and practices with which these may be associated.

On the other hand, consulting different groups of staff, and eliciting their views of how other individuals and occupational groups reacted to self-harm, offered an insight into the complex interrelationships between workers of different grades and disciplines. In turn, this allows for a more layered and complex understanding of prisoners' and staff's social networks. "Easy communication" (Lee, healthcare staff, 356) within and between

disciplines, and a clear understanding of everyone's roles and responsibilities, are likely to have a positive impact on both prisoners and staff. In this field of research, the finding that workers from all disciplines tended to "pass the buck to another department" (*Ibid.*, 67-68) was arguably as relevant and concerning as that of staff's negative views about (certain) prisoners.

9.5.2 Work Stress Literature and Social Constructionism

The work-stress literature offered a useful theoretical framework within which to conceptualise the difficulties and reactions of different groups of staff. However, emphasising the organisational and occupational contexts of their responses to self-harm may have led to underestimating the role of individual and non-prison related factors. Indeed, this had been a deliberate decision when considering issues around staff support and how workers may come to resist dominant, negative reactions (see Ch. 8.1.1). Analysing and discussing much of the data by occupational group (rather than at an individual level), also risk producing essentialist and dichotomised accounts, in turn reinforcing and overrating divisions between different groups of staff.

On the other hand, drawing on a critical social constructionist framework (Burr, 1995; Danziger, 1997; see also Ch. 3.1.5) meant that the discourses (re)produced by different groups of participants became as much "the objects of research" (Willig, 1999a, p. 43) as were their users. Using this approach within a critical realist perspective (Parker, 1999; see Ch. 2.11) proved particularly useful, as it allowed me to maintain a focus on the material 'reality' of participants' experiences, whilst considering - and problematising - the assumptions and implications of their "common truths" (Willott, 1998, p. 184), including the idea that prisoners may self-harm "just" for "attention" or "silly little things". To this end, being able to tease out the tensions and contradictions within and between dominant 'common-sense' discourses proved invaluable. This was perhaps especially the case in relation to staff's needs and preferences for support, which appeared to be rather more complex than if they had been taken "at face value" (Parker, 1999, p. 26).

9.5.3 'Task Demands'?

Tensions of this sort were arguably exacerbated by the method of data collection employed, and the type of language used in the interviews. Particularly in relation to staff, to be a) interviewed and b) asked to discuss one's "support" "needs" and *emotional/personal* reactions to self-harm, appeared to raise particular dilemmas and contradictions. Given that most staff seemed to prefer discussing these issues in a more informal and humorous manner, this may have been a rather un-naturalistic way of collecting data (see also Hepburn & Potter, 2003; Potter, 2004). If one believes that "interview data can only be used to make legitimate claims about what occurs in interviews" (Redley, 2003, p. 350), the findings of this study may not apply very well to the everyday life of prison, or reflect the ways in which staff and prisoners may talk to and amongst each other.

Theoretically, however, this was of rather limited concern. From a post-structuralist perspective, the notion that knowledge is anything other than situated and contested has come under scrutiny. Arguably, the suggestion that 'ecologically valid' "observation and measurement are the keys to good science" (Parker, 1999, p. 27) is as problematic as the idea that participants may be holding back their 'true', coherent selves. Indeed, the presence of contradictions in participants' talk may not only be considered 'normal', but is arguably positive, as it opens up possibilities to challenge rigid and essentialist discourses (Billig, 1995; Billig et al., 1988).

9.5.4 Ethical Concerns

What was arguably more concerning was that these tensions may have reflected or been associated with some degree of discomfort. The interviews may have prompted staff and prisoners to reflect upon certain issues in ways that were new to them, and potentially in conflict with occupational and organisational cultures. Whilst this may not necessarily be a negative process - and indeed, many made comments to the opposite effect - the pressures of doing so in a face-to-face situation, and in the presence of a tape recorder, cannot be overlooked. Moreover, the practicalities of conducting research in the less than ideal interview rooms provided in prisons, and within only one establishment, may have rendered participants nervous of being overheard and/or identified by others within the prison. With hindsight, it was naïve to suppose that reassuring participants of the

(limited) confidentiality of their answers may be sufficient to appease these anxieties. Indeed, the very notion of confidential research may be viewed as problematic and potentially misleading. As noted by Parker (2005, p. 17), "there is no such thing [...] because the aim of the work is always to 'discover' something new and to show others".

The greater anonymity offered by a self-report questionnaire may have offered participants greater reassurance, but would not have provided the same richness of data, or allowed participants to tell their stories, in their own words. As remarked by Luke (officer), amongst others, it also risked being "just regarded as a complete joke":

> Surveys are a waste of time (.) in a place like this. They are used as paper aeroplanes, that's it. If you sent a survey round to everybody in this gaol, you probably wouldn't even get 25% back. (390-392)

These ethical dilemmas do not only pertain to how data are collected, but also to how they are stored, analysed and disseminated. Maintaining the participants' anonymity at all times was arguably not enough to protect their identity. Further steps were therefore taken to ensure that interviewees would not be identified by fellow participants, or others within and beyond their establishment. This included withholding information about the participants' exact roles and locations within the prison, as well as their detailed demographic characteristics.

Further concerns included the ethical implications of how deeply and critically transcripts should be analysed, and by whom. Where possible, it may have been appropriate to involve participants more in the later stages of the research, including in the interpretation and analysis of their accounts. Although it is perhaps unavoidable for the researcher to have the 'last word' (at least until each reader will bring his/her own interpretations to the material), the risks of over-interpreting data and misrepresenting those being studied (see Burman, 1997; Opie, 1992; Reay, 1996) may be reduced within a more participatory framework. Regrettably, the practicalities of conducting research in prison do not lend themselves well to these principles. Nevertheless, I tried to make my interpretations as visible as possible, and to present them in ways that would preserve their political impetus, without upsetting or damaging participants (Ciclitira, 1998, pp. 23-24).

To this very aim, it is important to reiterate that although the findings of this study may be situated, contested, and 'non-generalisable', they are, nonetheless, set within broader organisational and institutional structures, and, as such, reflect wider discourses and practices. Being reflexive about the limits and limitations of one's work is not the same as suggesting that this cannot - or should not - have some theoretical, practical and political applications. Indeed, there would arguably be little point in conducting research if that was the case, or for interviewees to take part in it.

9.6 Recommendations for Policy

There is some disagreement as to whether researchers can and should be making recommendations for policy. For instance, Widdicombe (1995) has discussed the dangers of reification, i.e. that accounts and interventions "intended to liberate oppressed groups [...] end up simply locking them within different restrictive discourses" (Willig, 1999b, p. 9). Drawing on Foucauldian models of power, others have drawn attention to the complex and perhaps paradoxical relationship(s) between "resistance" and "regulation" (see e.g. Burman et al., 1996), whereby the former risks "reproducing rather than transforming precisely that which is being protested" (Bordo, 1993, p. 177). Indeed, from this perspective, the production of knowledge about self-harm (regardless of whether one then proceeds to make recommendations for practice) is likely to "perpetuate the spiral of disciplinary power" that "regulates" and "constitutes" it in the first place (Groves, 2004, p. 62).

As previously contended (see Ch. 2), it is important to be mindful of the possibility that one's discipline or "progressive policy recommendations" (Willig, 1999b, p. 9) may not be as benign as intended. This may be particularly the case when carrying out research under the auspices of psychology, which, wittingly or unwittingly, has had an important role in the (re)production of oppressive practices and discourses, and "in pathologising those who fail to fit its norms" (Burman et al., 1996, p. 5). This study, along with others (e.g. Groves, 2004; Kilty, 2006), suggests that "psy-discourses" (see Kilty, 2006; Rose, 1985) are so heavily implicated in the social (mis)construction of self-harm that to critique and deconstruct these accounts may be as useful, if not even more so, than any practical recommendation or intervention one may suggest.

However, social critiques of oppressive discourses may have a limited and very slow impact outside the world of academia, partly due to the esoteric language they tend to employ, making them inaccessible to wider audiences, and partly because they often do not conform to the dominant (quantitative) 'evidence-based' policy paradigm. Failing to apply these in more 'practical' ways (e.g. by incorporating them in training) risks leaving unchallenged said practices and discourses, further perpetuating their hegemony. In turn, this may render unethical the very practice of asking people to share their time and (often difficult) stories with a researcher, if nothing (or nothing 'positive') may result from it.

A good compromise to these dilemmas comes from the assertion that one's policy recommendations should be "provisional and tactical, rather than final and absolute" (Willig, 1999b, p. 13). Arguably, the context of this research is such that a global solution to self-harm may be especially unfeasible and counter-productive. Firstly, it would risk regulating and (re)producing self-harm, as well as negative staff reactions (see e.g. Groves, 2004). Secondly, it may bring further legitimacy to the (over)use of imprisonment, by suggesting that - even in the current conditions - prisons are capable of dealing with the complex needs of those in their custody, and of providing "a safe environment for all who live and work there" (Safer Custody Group, 2001, p. 1). This, in turn, may aggravate some of the problems discussed in Chapter 8 in relation to Carlen's concept of imaginary penalty. In other words, it may lead to prison staff having to act (even more so than they might do now) "as if" they can help to prevent or reduce self-harm, whilst insisting that they do not have the necessary skills or resources to do so (Carlen, 2007, p. 11; see also Carlen & Tombs, 2006). "After all, why focus research [and policy] efforts on making imprisonment less painful when we should be using our energy to tear prisons down altogether?" (Liebling & Maruna, 2005, p. 20).

On the other hand, it is equally important to emphasise that prisons *do* exist, and whilst they do we cannot just "stand back and wish them away" (*Ibid.*, p. 21):

> It does no good to cry without effect in the wilderness of unresponsive public opinion [...] Prisons are not an abstraction. They are a painful, tangible reality for [...] inmates [and] their keepers [...] These fellow

> humans are stressed now, and must be helped to survive. (Toch, 1982, pp. 41-42)

Not only do prisons exist, "they do have the responsibility of care for those in their custody and can [at least in part] achieve this in co-operation with specialist groups outside prison" (Loucks, 1997, p. 61). In the current context, abandoning a prison reform agenda in the name of an abolitionist one may lead to prisons becoming little more than warehouses. This can create even further harm (see e.g. Cavadino & Dignan, 2002), and certainly does little to prepare prisoners "for their return to the community in a way which makes it less likely that they will re-offend" (Woolf, 1991, para. 9.20).

In view of these tensions, it may be useful to focus on "the minimum that prisons can be expected to achieve by way of practice" (Rickford & Edgar, p. 68), rather than on ideal, but unrealistic, interventions. Given the far from ideal 'macho managerialism' that continues to be pervasive in prison, ensuring that such minimum standards are somehow measurable, enforceable and mandatory may be key to their effective implementation. It is with these caveats, that the following recommendations are made.

9.6.1 Safe Self-Harming

Consistent with previous studies, this research has suggested that attempting to stop self-harm at all costs can be unfeasible and counter-productive. The principles of "harm minimization" and "safe self-harming" (see e.g. Pembroke, 2007; Shaw & Shaw, 2007) (including the notions of increased "(short-term) risk acceptance" and "patient responsibility" (Rickford & Edgar, p. 67)) are thus likely to benefit both prisoners and staff. Whilst these may not always lend themselves well to the realities of prison life (*Ibid.*), it is arguably paramount that the possibility of greater tolerance to (some forms of) self-harm begins to receive serious consideration. As noted by Rickford and Edgar (2005), this would be an important first step towards the requirement of "equivalence of treatment" in prisons (see HM Prison Service & NHS Executive, 1999; Home Office, 1991; Wilson, 2004), bringing prison healthcare in line with current NHS and NICE guidelines. Setting aside problems of resources, this is unlikely to happen as long as the issue of self-harm in custody continues to be "buried" (Howard League, 1999) within the framework of suicide, and suicide *prevention*. Greater attention needs to be paid to

non-suicidal self-harm as a 'serious' issue in its own right, and one that does not only involve women and young people.

However, as argued by Shaw and Shaw (2007, p. 33), "'safer self-harm' policies may constitute just the starting point in the process of changing services so that they respond more helpfully to people who self-injure". Nor should they exclude attempts to prevent or reduce the incidence of self-harm in custody. These, however, should not aim to prevent prisoners from self-harming by reducing their means of doing so, nor by increasing surveillance (see Power, 1997), but rather by creating a climate where prisoners may feel less inclined to use self-harm as a coping strategy. As argued by the Prison Reform Trust (1996) in relation to suicide, these feelings:

> Are less likely to take root [...] in the establishment where regimes are full, varied and relevant; where staff morale is high and relationships with inmates positive; where good basic living conditions are provided; where every effort is made to encourage contact with family and the community. (As quoted in HMCIP, 1999, p. 57)

9.6.2 Looking Beyond Self-Harm

The findings of this study also point to the need for greater awareness of the issues that may underlie or be associated with non-suicidal self-harm, and, more generally, of the complex needs of men in prisons. Whilst feminists and prison reformers have drawn attention to the difficulties of women and young people in custody (e.g. Carlen, 2002; Howard League, 2001; Solomon, 2004), the clear indications that many men in prison have also suffered abuse, trauma and victimisation (and sometimes continue to do so) is often overlooked, as are their missing their families and loved ones outside. Although imprisonment is not intended or resourced to address these specific problems and vulnerabilities (Loucks, 1997), to increase staff awareness and understanding of these issues is an important and achievable first step. Simple practical arrangements such as allowing prisoners who fear being (re)victimised to shower in private, may also enhance their well-being (see also McQueen, 2007).

Beyond and aside from self-harm, it was clear from the accounts of staff and prisoners that the needs of drug users and prisoners with mental health issues (especially those

with a 'personality disorder') were not only often left unmet, but tended to be trivialised as "minor" and "silly". These attitudes need to be addressed in training and supervision, *and* greater resources allocated to all of these areas (see also Ch. 5.5.1). Clearly, there needs to be more than one part-time detox doctor in a prison of 1,500 inmates. As all healthcare provisions (see above), a prison's programme of detoxification should be equivalent to what is available in the community, *not* "shorter (2) and not in so much quantity" (Anthony, healthcare staff, 124).

9.6.3 Staff Support

In agreement with the then Chief Inspector of Prisons, "prison staff have the ability to provide this service but need the training, leadership, motivation and time to do it" (Home Office, 1990; as quoted in Inch et al., 1995, p. 170). For a policy so heavily reliant on 'good' staff-prisoner relationships, "care" and "teamwork" (see HM Prison Service, 2005a), the current suicide and self-harm strategy pays surprisingly little attention to the needs of staff, particularly in relation to repetitive, non-suicidal forms of self-harm. In view of NOMS' duty of care to its prisoners *and* staff (see Ch. 8.1.1), adequate support of workers in this (and indeed other) areas of work should not be viewed as a "luxury" or inconvenience, but as an employee right, an employer duty and a priority.

Given the current shortage of resources it may be reasonable (though perhaps not 'ideal') for some staff to be trained and supervised more than others, and to have more specialised roles in relation to this area of work. However, *all* staff should have at least some basic and *mandatory* training on self-harm. This should aim to challenge the unhelpful stereotypes and rigid dichotomising identified through this study, in an "engaging" way (Luke, officer). At present, staff who are not due to become ACCT assessors are only provided (superficial) "reminder material" in a self-directed pocket size information guide (see HM Prison Service, n.d.). This is arguably insufficient. The practice of including information about self-harm, especially repetitive self-injury, under the heading "personality disorder" (e.g. Musselwhite, Freshwater, Jack, & Maclean, 2004; UKCC, 1999) also needs to be reviewed. This risks reinforcing and perpetuating unhelpful stereotypes, and obscuring the role of wider systemic and institutional issues.

Arguably, more questions need to be raised about what knowledges and truths about self-harm are being taught, by whom, and with what implications.

Staff should not only receive training "to equip them to understand and care for people who have self-harmed" (NICE, 2004, para. 5.5.6.1), but also be provided regular opportunities to learn, discuss and reflect on how they may be affected by this issue, and what support may be available to *them*, as opposed to prisoners. Current provisions only formally acknowledge and address "stress reactions following a suicide or attempted suicide" (HM Prison Service, n.d., p. 24), overlooking the potential effects on staff of working with prisoners who self-harm with no apparent suicidal intent. In this context, the possibility that staff themselves may self-harm (whether or not as a result of working with prisoners who do) also needs greater recognition and understanding. Despite increased awareness of the risk of "contagion" (e.g. Hawton et al., 2006) of self-harm amongst prisoners, the motivations, needs and concerns of staff who self-injure remain unexplored (however, for a discussion of suicide and suicide attempts amongst prison officers see Liebling & Krarup, 1993). In an environment so ostensibly hostile to people who self-harm this is clearly problematic.

This study suggests that these negative reactions are not only associated with how "staff make sense of self-harm" (Ben, specialist, 156-157), but also with how they may (mis)understand their own roles, and those of other staff groups. Clearer and realistic guidelines should therefore be available clarifying what is expected of staff (see also Liebling, Tait, et al., 2005) and what, in contrast, are the limits of one's role(s) and responsibilities – and not only in relation to self-harm. Similar guidelines may contribute to a "more joined-up approach to mental health" (Medlicott et al., 2004, p. 10) and drugs in prisons, and generally enhance the regime.

In addition, and like prisoners, staff need to feel supported and satisfied beyond this specific area of work. Increasing staffing levels may be an important step in this direction, as is the promotion of "visible leadership which recognises the human dimension, shows enthusiasm for people's efforts and promotes feelings of self-respect and self-confidence" (Learmont, 1995, p. 172; see also Woodcock, 1994).

Moreover, both prisoners and staff may benefit from being more involved in the development and delivery of interventions. For instance, NICE (2004) guidelines suggest for "people who self-harm [...to be] involved in the planning and delivery of training for staff" (para 1.1.2.3). Whilst it may not always be feasible for prisoners to have a direct role in training staff, it is certainly advisable for them (as well as staff) to be consulted regarding the designing and evaluation of training.

9.6.4 User-Led Policy and Research: Some tensions and recommendations

However, the concept of user-led policy is far from uncontentious. By encouraging self-care and self-regulation under the guise of choice and empowerment (Kilty, 2006; Rose, 1996), it may well act as a "dominant form of social control" (Gastaldo & Holmes, 1999). Nevertheless, *not* incorporating staff's and prisoners' opinions into policy is an even more dangerous strategy. Although their needs may not always coincide or be compatible, listening to their voices is arguably key to making prisons a safer environment, for all who live and work there.

To this aim, further research is needed to raise awareness and understanding of their needs, and to evaluate the current and potential impact of different types of interventions on prisoners and staff, in different types of establishments. In an environment where rates of self-harm continue to rise, and staff believe that nothing can be done to stop this, "resolution" (Sinclair & Green, 2007) of repetitive self-harm may be an especially useful area to explore. Both in prisons and outside, most studies have focused on what may initiate and maintain self-harming behaviour, with fewer attempts being made to understand (particularly from a phenomenological perspective) why and how people may come to stop feeling the need to self-harm. Given the disadvantaged backgrounds of most people in custody, and the damaging effects and "pains" of imprisonment (Sykes, 1958), the question of why there are not even *more* prisoners harming themselves may also provide some useful insights.

9.7 Further Suggestions for Future Studies

In addition, exploring international and community examples of positive practice may offer some useful suggestions for the UK prison context. To do so using mixed and/or quantitative methods may help to increase the impact of this research on policy. On the

other hand, collecting more "naturalistic" (Potter, 2004) data about staff's (negative) responses to self-harm (for example by examining the language of their entries on ACCT documents, or observing staff-prisoner interactions in more informal ways) may provide a richer and more powerful picture of an issue that continues to remain unresolved.

This, in itself, is arguably one of the most fruitful areas for future studies to investigate. Whilst this research may have helped to deconstruct and contextualise these responses, the finding that staff tend to be negative towards prisoners who self-harm is certainly not new, nor is the suggestion that prisoners and staff need to be supported in a more proactive, holistic and inclusive manner. Indeed, these recommendations have been made at least for the past two decades (e.g. Home Office, 1990; Inch et al., 1995), and yet the "prison in its current form is singularly unsuccessful in both these functions" (Groves, 2004, p. 60). Arguably, rather than to keep raising the same criticisms and suggestions against a system that has indeed incorporated these in its official rhetoric (e.g. HM Prison Service, 2001; Safer Custody Group, 2001), we need to start asking why these continue to fail, and in whose interest. Nobody has made this point more eloquently than Foucault (1977, pp. 271-272):

> Is it not the supposed failure part of the functioning of the prison? Is it not to be included amongst those effects of power that discipline and the auxiliary technology of imprisonment have induced in the apparatus of justice, and in society in general, and which may be grouped together under the term 'carceral system'? If the prison-institution has survived for so long, with such immobility, if the principle of penal detention has never seriously been questioned, it is no doubt because this carceral system was deeply rooted and carried out very precise functions [...] Perhaps one should reverse the problem and ask oneself what is served by the failure of the prison: what is the use of these different phenomena that are continually being criticized [...]

As concluded by Groves (2004, p. 53), "self-mutilation must, on some level, be construed as a failure of the prison". The data presented here suggest that negative staff attitudes may also be viewed as symptomatic of the failure and "pathology of the prison" (Thomas et al., 2006). Arguably, some "provisional and tactical" (Willig, 1999b, p. 9)

recommendations can and should be made to enhance the well-being of both prisoners and staff. However, in the longer term, it is this wider failure, and its functions, 'successes' and normalization, that we need to expose and critique.

Concluding Remarks

Ending the work of almost seven years[25] with more questions and doubts is both exciting and disheartening. On the one hand, it reminds me of how passionately I still feel about this topic, and about the politics that inspired this research. Further, to make some recommendations for future studies is an almost standard, and perhaps expected, way of concluding a research report. I would have been rather worried had I not been able to do so. Nevertheless, it is difficult not to ask oneself whether these (perhaps not so) new questions should have been the focus of one's work in the first place; what should have been done differently; or even whether it was all worth it. However, the issue is not necessarily that of asking the 'right' questions (if they indeed exist), but also of asking them at the right time, of the right people, and conveying the findings to the right audiences.

Having conducted undergraduate, postgraduate and now doctoral research on self-harm in prisons, my perception of what is 'common sense' in this field, and what is not, may be rather skewed. Although several months were spent pouring over this thesis worrying over the perhaps inevitable (and often useful) 'so what?' question, the continuing rise in the number of people in prisons, and who harm and kill themselves in custody, are a stark reminder that the stories of the 58 staff and prisoners I interviewed are not as well-known or obvious as I simultaneously hope (politically) and fear (in terms of producing 'original' and publishable academic work).

The issue of self-harm in prisons remains - perhaps intentionally - a "hidden problem" (Howard League, 1999). As well as questioning the history, power and functions of this invisibility, it is important to keep building an evidence-base to show exactly what is being hidden, and with what implications. We *need* more research, more questions, more accounts of what living and working in prisons can be like. Perhaps above all, we need more and bigger audiences. If the headlines of tabloids (which remain the most widely read 'papers' in the UK - see e.g. Office for National Statistics, 2002) are anything to go

[25] This includes my Undergraduate and MSc projects.

by, the messages of those researching this area (whether or not under a prison reform agenda) continue to remain subjugated.

Clearly, there are no single or easy solutions to any of these problems. Just as there may be no right questions, there are possibly no right answers as to how we may increase awareness of self-harm in prisons, or enhance the well-being of those dealing with this issue. This, however, does not mean that we have to stop asking these questions. Whilst this research has focused on the needs of (some) staff and prisoners, it is important not to forget that their fellow colleagues and prisoners, friends and family, may also be affected by self-harm in custody, and by the wider issues of which it 'speaks'. Indeed, if the high rates of self-harm in prisons are a symptom of the poor "health" (HMCIP, 1999), "moral performance" (Liebling & Arnold, 2004) and legitimacy of our prisons and criminal justice system (see also Liebling, Durie, et al., 2005), it could be argued that we are all affected by them. Under these conditions, prisons are unlikely to succeed in 'rehabilitating' offenders and preparing them "for their return to the community in a way which makes it less likely that they will re-offend" (Woolf, 1991, para. 9.20). In addition, the failure to provide morally defensible and "healthy" conditions to prisoners is arguably something for which we are all partly responsible and implicated. "The test of a civilization is in the way it cares for its helpless members" (Buck, 1993, p. 73).

This thesis opened with quote from Liebling (1995, p. 183), proposing that our research needs to "reflect the reality of this pain [of imprisonment] and its consequences". However, many would argue that research does more than just reflect reality (see e.g. Kilty, 2006). It can help to resist certain 'truths' and realities, whilst constructing others. Hopefully, we can be part of creating a less painful one.

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Glossary

Part 1. Staff Groups Taking Part in the Research: Explanatory notes and descriptions of professional roles

Most of the literature concerned with staff in prisons, including research on their responses to prisoner self-harm, has predominantly and often exclusively focused on uniformed discipline staff, particularly prison officers (e.g. Arnold, 2005; Crawley, 2004). Although (few) members of other staff groups have at times been included in broader "prison staff" samples (e.g. Borrill, Teers, Paton, Regan, & Cassidy, 2004), these have almost inevitably been mainly comprised of officers (e.g. Liebling & Krarup, 1993). Indeed, the term "prison staff" has often been used as synonymous for "prison *officer*" (e.g. Liebling, Tait, Durie, Stiles, & Harvey, 2005; Willmott, 1997), even when reporting the findings of research conducted with staff from other disciplines.

This is in spite of the recent influx of "outside" specialists and "treatment professionals" into the prison world (Schaufeli & Peeters, 2000), such as education staff, Samaritans, detox specialists, and mental health professionals. In the context of the recent shift in policy and practice towards multi-disciplinary team work (HM Prison Service, 2005a), this means that a variety of staff are involved in the care and management of self-harm in custody, albeit with different levels of contact with prisoners who self-injure. For example, although officers on the wings tend to have more day-to-day interaction with prisoners, and are more likely to 'discover' an incident of self-harm, prison nurses and doctors are those who deal with prisoners' self-inflicted wounds, and are often the first to discuss with them the circumstances surrounding their self-harming. Members of the prison chaplaincy and prison in-reach workers, as well as psychologists and counsellors, are also likely to work (in a more or less structured way) with prisoners who self-injure, and hence may also be affected by this issue. Not only is there little research on the experiences, reactions and needs of non-discipline staff dealing with prisoner self-harm, recent evidence suggests that they do not benefit from the same level of support available to officers on the wings, and are often 'forgotten', or excluded, from the critical incident debriefs which sometimes follow an incident of self-harm or a self-inflicted death in custody (Safer Custody, personal communication, 6th September 2004).

For these reasons, the current research was concerned with the impact of male, repetitive, non-suicidal prisoner self-harm on different groups of staff. In light of the work stress literature (see Ch. 3.1.3), the assumption was made that different staff groups may not react to self-harm in the same way, because of their different roles, responsibilities and occupational cultures. Whilst it may have been unfeasible to include in the research representatives of all staff and volunteer groups working in prisons (particularly as this was a lone qualitative project), interviews were conducted with members of three groups of staff: officers, healthcare staff (including doctors and nurses), and specialists (see below for descriptions of professional roles). Uniformed staff on the wings and nurses formed the largest participant groups in this research as they have the most contact with prisoners who self-harm (see also Ch. 2.6 - 2.6.1).

1.1 Descriptions of Professional Roles

(i) Officers: Uniformed staff responsible for "the security, supervision, training and rehabilitation of people committed to prison by the courts" (Grayburn, 2006, p. 1). In other words, prison officers are expected to "punish, deter, isolate and rehabilitate offenders while at the same time maintaining order and inmate productivity" (Kauffman, 1988, p. 45).

Prison officers are the largest staff group in prisons, and have the greatest degree of contact with prisoners (Bryans & Jones, 2003; see also Liebling & Price, 2001). In England and Wales there are three uniformed officer grade: prison officers (forming the largest, 'basic' grade group), senior officers (S.O.) ("who act as first line managers" (Bryans & Jones, 2003, p. 640)) and principal officers (P.O.) ("who manage units of accommodation, or tasks such as security and who line manage senior officers" (*Ibid.*)). Please note that the term "officer" is used in this thesis to refer to all three officer grades, rather than to connote (basic) grade. Nevertheless, a breakdown of the officer sample by grade is provided in Ch. 2.6.1.

(ii) Healthcare Staff: Medical staff working in prisons, including doctors and nurses. In the international literature, these are also referred to as "treatment staff", as well as

"correctional", "forensic" and "prison" doctors and nurses. Although there is some debate as to whether doctors and nurses can, and indeed should, be considered as being part of the same staff group (e.g. Davies, 2003), it may be argued that the similarities between these professional groups can surpass their differences, especially in the context of prisons, where doctors and nurses are united in their being 'Other' to officers. In addition, and despite the nursing "gaze" being perhaps more "relational" and informal than that of doctors, medicine and nursing are said to share a "medical way of seeing things" (Hamilton & Manias, 2006, p. 89).

Please note that correctional healthcare is a "nurse driven system" (Flanagan & Flanagan, 2001, p. 68). Both in the UK and abroad, nurses tend to be the primary healthcare providers in prisons (see e.g. Royal College of Nursing, 2001). For this reason, all but two of the 15 participants in the healthcare staff sample were nurses.

It should also be noted that, in England and Wales, prison nurses comprise both registered civilian nurses (including primary care, mental health, substance misuse and dual diagnosis nurses) and healthcare officers, trained prison officers who have completed specialist training in "basic" healthcare (Walsh, 2005; for more information about the classification of nurses working in prisons see Willmott, 1997). The latter, however, are perhaps best viewed as "specialist" prison officers (*Ibid.*), who, in the words of Willmott (1997, p. 334), "have different attitudes [to civilian nurses] and don't share the same value base [...] pay and conditions". Indeed, the two healthcare officers interviewed as part of this research seemed to position themselves as officers, rather than medical staff, and, for this reason, were included in the officer sample.

(iii) Specialist Staff: Although there is no official or agreed definition of specialist staff, this term may be used to describe staff from different grades, disciplines and professional backgrounds, who have a specific role with prisoners and/or other staff groups. In the present study, this definition was applied to those practitioners and others whose specialised role was to support self-harming prisoners and/or staff dealing with this issue. This included: the Governing Governor, Safer Custody Governor and Suicide Prevention Co-ordinator at the establishment, as well as members of the prison In-Reach Team, Psychology, Chaplaincy, the Staff Care and Welfare Service (SCWS) and the

local Staff Care Team (PICT). A brief description of the role of each of these specialists is presented below, in alphabetical order.

Chaplain

In England and Wales, "chaplains from a wide range of faith traditions work with the Prison Service, including Buddhist, Church of England, Free Church, Hindu, Jewish, Muslim, Roman Catholic, and Sikh" (HM Prison Service, 2004b, p. 1). Their role is to "serve the needs of prisoners, staff and faith communities" (*Ibid.*).

Governors

Prison governors manage prisons and "remain ultimately responsible for everything that happens behind the [prison] walls" (Bryans & Jones, 2003, p. 643). Whilst their precise work and responsibilities vary according to the size and type of prison, their general role encompasses a number of key tasks:

> Managing the business of the prison, managing staff and prisoners and managing boundaries [...] delivering against key performance indicators and targets, financial control and management, self-audit, planning for emergencies, fostering effective public relations, maintaining order, providing constructive regimes for prisoners, developing and managing staff and dealing with disputes, outside agencies and the public. (*Ibid.*, p. 644; see also Bryans, 2007; Bryans & Wilson, 2000; Walsh, 2005)

The Governor in charge of each prison is also commonly referred to as "**Governing Governor**" or "Number 1 Governor". He or she will be supported by a number of Operational Managers and Senior Managers, traditionally referred to as "Governor Grades" (see Liebling & Price, 2001). This may include a "**Safer Custody Governor**", responsible for ensuring that the prison is "a safe environment for all who live and work there" (Safer Custody Group, 2001, p. 1).

In-Reach: As part of the national drive to deliver mental health services to prisoners (see Department of Health, 2001; Department of Health & HM Prison Service, 2002), community mental health in-reach teams are now operating in many establishments in England and Wales. Their aim is to "improve the mental health care provided to

prisoners who need it and to help in providing the correct amount of appropriately trained and skilled staff' (Emslie et al., 2005, p. 17; see also Armitage, Fitzgerald, & Cheong, 2003).

PICT Co-ordinator: Staff member responsible for co-ordinating a prison's Staff Care Team. As established by Prison Service Order 8150 (HM Prison Service, 1998, para. 1.1), "care teams are selected locally from staff volunteers, reflecting the range of disciplines within the establishment and in proportion to the size and type of establishment. Their basic tasks are:

(i) To give immediate and early practical and befriending support to colleagues following an incident at work;

(ii) To listen to colleagues in order to enable them to make sense of what has happened and their reactions to it;

(iii) To liaise with Staff Care and Welfare Service (SCWS) when colleagues request further help after incidents at work;

(iv) To provide information to colleagues of sources of help for non-incident problems (e.g. relationship problems, general stress, alcohol abuse, debt, bereavement etc)."

(See also HM Prison Service, 2003; HM Prison Service, 2004c)

Prison Psychologist: Psychologists working in prisons come from a variety of backgrounds and (sub)disciplines, including Forensic, Counselling, Organisational and Health Psychology (see Towl, 2002, 2004). Their main responsibilities include:

(i) The design, delivery and evaluation of psychological interventions to reduce prisoners' risk of re-offending (commonly known as Offending Behaviour Programmes);

(ii) One-to-one and group counselling (including in relation to self-harm);

(iii) Risk and clinical assessments;

(iv) Staff selection, recruitment and training.

Staff Care and Welfare Officer: Representative of the National Staff Care and Welfare Service (SCWS). Amongst other duties, a SCWS officer organises critical post-incident

debriefs and refers staff for confidential and independent counselling (see HM Prison Service, 2003; HM Prison Service, 2004c).

Please note that, in relation to prisoner suicide and self-harm, these provisions tend to be only activated following a self-inflicted death or a "serious" incident of self-harm (HM Prison Service, 2004c). Moreover, critical incident debriefs are not currently mandatory, but take place "when requested by Governors" (*Ibid.*, para. 5), whereas referrals to a counsellor need to be requested by the individual member of staff requiring assistance (*Ibid.*, para. 6).

Suicide Prevention Co-ordinator (SPC): Although Governors have overall responsibility for the implementation of suicide and self-harm prevention strategies within their establishments, much is delegated to SPCs. These support Safer Custody Governors (see above) in their duties, holding key responsibilities for the implementation and development of local policies and procedures (see e.g. HM Prison Service, 2003). Please note that SPCs may be drawn from any grade or discipline.

Part 2. Glossary of Prison Terms

Assessment Care in Custody and Teamwork (ACCT): The system for the care of prisoners at risk of suicide and self-harm in prisons rolled out in October 2005 (see HM Prison Service, 2005)

- **ACCT Assessor:** When an ACCT plan is opened, assessors are the members of staff whose responsibility it is "to interview the person at risk within 24 hours. The interview will identify the risk and contribute to the first Case Review" (HM Prison Service, n.d., p. 6).

- **ACCT Manager (or Case Manager):** ACCT Managers organise and chair ACCT Case Reviews (see below). Amongst other responsibilities, they are expected to "ensure CAREMAPs are actioned; ensure key people attend and contribute to Case Reviews; involve the prisoner/trainee" (*Ibid.*, p. 11).

- **ACCT Plan or ACCT Form:** Form opened "in the event of any incident of self-harm (where there is no existing CAREMAP), or cause for concern that a prisoner/trainee may be at risk" (*Ibid.*, p. 5).

- **ACCT (Case) Reviews:** Regular meetings where the care and support of "the person at risk" are reviewed.

- **CAREMAP:** "Care and management plan" drawn up by "the Case Review Team [...] with the person at risk", to set out "how the person at risk is to be managed" (*Ibid.*, p. 7).

- **"Being on an ACCT":** In prison jargon, expression used to denote prisoners deemed to be at risk of suicide and self-harm.

F2052SH (or "Self-Harm At-Risk Form"): The name of the form used to identify prisoners at risk of self-injury and/or suicide prior to the introduction of ACCT.

First Timer: In prison jargon, term used to denote a prisoner who is in custody for the first time in his/her life.

HM Chief Inspector of Prisons (HMCIP) for England and Wales: Appointed from outside the Prison Service, and reporting directly to the Home Secretary, HMCIP aims:

> To provide independent scrutiny of the conditions for and treatment of prisoners and other detainees, promoting the concept of 'healthy prisons' in which staff work effectively to support prisoners and detainees to reduce reoffending or achieve other agreed outcomes. (HMCIP Statement of Purpose, HMCIP, 2006, p. 2)

Key Performance Indicators (KPIs) are quantifiable benchmarks used by the Prison Service to measure its successes, progress and failures. They are "set each year by the Government and are approved by Ministers on the basis of advice given by the Chief Executive of the National Offender Management Service (NOMS). Performance against Key Performance Targets is monitored regularly throughout the year and published each year in the Annual Report and Accounts" (HM Prison Service, 2005b, p. 1). At the time of writing, the KPI in relation to self-harm and suicides in custody is "to ensure the rate of self-inflicted deaths in 2006-2007 does not exceed 112.8 per 100,000 of the prison population" (HM Prison Service, 2006, p. 13).

Lie Down: In prison jargon, procedure whereby a prisoner is temporarily transferred to another wing or prison.

Lifer: In prison jargon, term used to denote a prisoner serving a "life sentence" or "indeterminate sentence".

Listeners: Prisoners trained by the Samaritans to "befriend and care" for other prisoners, in complete confidentiality (Davies, 1994). Listener schemes now run in the majority of prisons in England and Wales (for more information see Snow, 2002b).

Local Care Team (PICT): See PICT Co-ordinator (part 1).

Local Prisons: Local Prisons deal with men and young offenders who are sent directly from the courts, either when remanded in custody before trial or after conviction or sentence. These establishments can hold prisoners for the duration of their sentences, or only for the initial assessment and classification of convicted prisoners before their allocation to another prison to serve their sentences.

NOMS (National Offender Management Service): In June 2004 the Probation and Prison Services were merged to form NOMS. The main reasons behind this radical re-organisation were to improve information sharing between the two services, provide "strategic end-to-end management of offenders across their sentence" (Carter, 2003, p. 23), and increase accountability (Home Office, 2003).

Performance Test: Performance testing is a form of "market testing" whereby the overall performance of an establishment is tested against a set of benchmarks (HM Prison Service, 2004a). It is mainly "used by the Prison Service as a means of improving the performance of underperforming public sector prisons" (House of Commons, 2005, column 458W).

Personal Officer Scheme: Formal scheme whereby named prison officers have special responsibilities for a small numbers of prisoners (generally five to ten). "The duties involved normally include interviewing, report writing, attendance at relevant review boards, and generally getting to know the prisoner for 'welfare' purposes" (Liebling & Price, 2001, p. 69).

Purposeful Activity: In prisons, term used to refer to a range of "activities that are likely to benefit [prisoners]" (HMCIP, 2004, p. 109). This may include "literacy, numeracy and language support, employability and vocational training, and social and life skills" (*Ibid.*).

Safer Custody Group: The Safer Custody Group, Prison Service HQ, was established in April 2001 with the aim to "reduce the incidence of suicide and self-harm by developing broadly based policies to make prisons safer places in which to live and work" (HM Prison Service, 2001, para 6.1).

Self-Inflicted Death: This term is used within prison-based research as an "all-embracing description of deaths arising from non-natural causes that appeared to be directly caused by the actions of the individual concerned" (HM Prison Service, 2001, para 3.4.1). This broad concept refers to all "apparent" (*Ibid.*) suicides in custody, and is generally favoured over the narrower term 'suicide', which only describes self-inflicted deaths when there is clear evidence (usually a suicide note) that the individual concerned intended to end his/her life.

Service Level Agreement (SLA): An SLA is a formal negotiated agreement regulating the level of service(s) an establishment is required to provide. Failure to comply with a SLA may result in an establishment being privatised (or 'contracted out').

Staff Care and Welfare Service (SCWS): see Staff Care and Welfare Officer (part 1).

List of Abbreviations

ACCT	Assessment, Care in Custody and Teamwork [replaces the F2052SH self-harm monitoring system]
BMA	British Medical Association
HC	Healthcare Staff
HMCIP	Her Majesty's Chief Inspector of Prisons
HMSO	Her Majesty's Stationery Office
NICE	National Institute for Clinical Excellence
NOMS	National Offender Management Service
PD	Person diagnosed with a 'Personality Disorder'
PICT	Local Staff Care Team
P.O.	Principal Officer
SCWS	Staff Care and Welfare Service
SLA	Service Level Agreement
S.O.	Senior Officer
SPC	Suicide Prevention Co-ordinator
WHO	World Health Organisation

UKCC	The United Kingdom Central Council for Nursing, Midwifery and Health Visiting
2052	Self Harm Monitoring Form [F2052SH]

Appendices

Index to Appendices and Explanatory Notes

1. Access
   a. Application to undertake research in HM Prison Service
      Application submitted in relation to the initial research project: "The Impact of Prisoner Self-Harm on Prison Officers: Experiences, reactions and support needs".
   b. Approval letter, Applied Psychology Group, NOMS
   c. Governor recruitment and follow up letters
      Please note that these materials were initially developed and submitted when the author was conducting her MSc research and planning to conduct a study on a National scale. Given the focus of her MSc project, this application only makes mention of the interview study with officers and specialist staff. As the doctoral research reported in this thesis was to be conducted in only one establishment, issues of access were negotiated directly with the prison's Governing Governor. (For further details of approval and access procedures to conduct research in prisons see http://www.phrn.nhs.uk/jail).

2. Ethics and Risk Assessments
   a. Ethical approval officers' and specialists' study
      Please note that it was difficult to seek a more specific ethical approval to interview specialists, as the latter form a very heterogeneous group. The specialists who took part in this study were recruited on a snowballing basis, so it was difficult to predict beforehand who might be approached or agree to take part in the research. However, all those who did participate, did so with their full, informed consent, as well as that of the prison's Governing Governor. Interviews with specialists were regulated by the same procedures that were in place with regards to discipline and healthcare staff, and involved very similar interview schedules (see Ch. 2.8.1).
   b. Ethical approval healthcare staff's study
   c. Ethical approval prisoners' study
   d. Risk assessment staff's study
   e. Risk assessment prisoners' study

3. Research Materials Staff's Studies
   a. Advert
      Please note that this advert was used at the beginning of the fieldwork, when interviews were being conducted with prison officers. As a result, it only refers to the latter (excluding healthcare and specialist staff). Given its scarce success (see Ch. 2.6), it was not used, or adapted for, subsequent studies.
   b. Consent form
      b(i). Consent form officers
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a. Information sheet
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5. Transcription Notation

6. Sample Transcript Summary

7. Unbound Appendix (loose copy provided for ease of reference)

a. Tables 1-4: Descriptive characteristics of participants
b. Descriptions of professional roles
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Appendix 1a: Application submitted in relation to the initial research project: "The Impact of Prisoner Self-Harm on Prison Officers: Experiences, reactions and support needs".

APPLICATION TO UNDERTAKE RESEARCH IN HER MAJESTY'S PRISON SERVICE

Name of researcher	Lisa Marzano
Project title	The impact of prisoner self-harm on prison officers: Experiences, reactions and support needs.

Appendix 1a: Application submitted in relation to the initial research project: "The Impact of Prisoner Self-Harm on Prison Officers: Experiences, reactions and support needs".

RESEARCHER(S) DETAILS

Surname: Marzano **Title:** Ms.

Forename(s): Lisa

Home Address: Middlesex University
School of Health and Social Science
Queensway
Enfield
EN3 4SA

Address to which all correspondence should be sent (if different from above):
As above

Contact Telephone Number: 0208 411 6861

Name, Status and Address of Research Supervisor (if appropriate):

Dr. Joanna Adler (Director of Studies)
Principal Lecturer in Psychology
School of Health and Social Science
Middlesex University
Queensway
Enfield
EN3 4SA

Dr. Karen Ciclitira
Senior Lecturer in Psychology
School of Health and Social Science
Middlesex University
Queensway
Enfield
EN3 4SA

Name and Address of Sponsoring Body (if appropriate):

This research is funded by the Economic and Social Research Council (ESRC).

If more than one researcher will be engaged on the project, please copy this page and provide details on all.

Please attach a CV for all researchers

Appendix 1a: Application submitted in relation to the initial research project: "The Impact of Prisoner Self-Harm on Prison Officers: Experiences, reactions and support needs".

1. PROPOSED RESEARCH - AIMS AND OBJECTIVES

Reason for undertaking research project:

Postgraduate research.

What is (are) the research question(s)?

The proposed investigation will endeavour:

1. To gain an understanding of the effect(s) of prisoner self-harm on prison officers, on both a personal and professional level. This will involve exploring the following questions:

a) What are the reactions of staff working with prisoners who self harm?
b) How do staff deal with working with prisoners who self-harm? (i.e. What coping methods do they employ?)
c) What impact does prisoner self-harm have on the lives and work of prison officers?

2. To learn about prison officers' experiences, understandings and training about self-harm, and discuss how these factors may affect the ways in which they respond to and manage prisoners who engage in self-destructive behaviours.

3. To gather information about existing sources of support for staff working with prisoners who self-harm, and identify examples of 'good practice'.

4. To explore the views and concerns of prison officers working with prisoners who self-harm, and to ask them if they have any ideas about how staff could be most effectively supported.

Is there related published research of relevance to the study?

Particularly relevant to the proposed research is the work which was undertaken by the Safer Custody Group (2003) on the impact on prison staff of a self-inflicted death in custody. Also of relevance to this study are a number of publications about suicide and self-harm in prisons (e.g. HM Inspectorate of Prisons, 1999; Liebling, A. 1992; 1995; Loucks, 1997; Snow, 1997, 2002; The Howard League for Penal Reform, 1999, 2001, 2003; Towl, 1997; Towl, Snow and McHugh, 2000), and the literature on the attitudes, issues and needs of professional working with people who self-harm, in prison (e.g. Towl and Forbes, 2002; Bailey, McHugh, Chisnall and Forbes, 2002), in clinical populations (e.g. Gough and Hawkins, 2000; Liebling, H. and Chipchase, 1995), and in the wider community (e.g. Arnold and Magill, 1996; Batsleer, Chantler, and Burman, 2003).

What are the potential benefits of the research:

- **to the Prison Service?**

The proposed study aims to increase knowledge and awareness about the issues and needs of staff working with prisoners who self-harm. The researcher intends to explore staff experiences, attitudes and problems in working with self-harm, an area which has not been fully investigated before (see Liebling, 1992; Bailey, McHugh, Chisnall and Forbes, 2002), and, arguably, has important implications for the lives and work of prison officers, not least of which for their crucial role in the prevention and management of self-harm in prisons (see Dexter and Towl, 1995; Power, 1997; HM Inspectorate of Prisons, 1999). Furthermore, this investigation endeavours to benefit the Prison Service by identifying examples of good practice, and suggesting strategies to support staff which are helpful and achievable within the prison context. The researcher will endeavour to highlight management and organisational issues which may help or hinder the development, implementation and use of staff support services, and discuss how such services may be beneficial to staff working with self-harm, as well as for prisoners in their care.

- **to academic knowledge in the field of study?**

The proposed study aims to contribute to the existing literature on the psychological effects of working with people who injure themselves, and, in particular, on the emotional reactions evoked by self-harm, and the ways in which workers cope with such feelings. Furthermore, the intended study aims to increase awareness about the concerns and (mis)understandings of people working with self-harm, and identify their perceived needs and suggestions for improving practice.

2. RESEARCH PLAN AND METHODOLOGY

Briefly describe the research methodology:
This study proposes the following methods:

- **Extensive review of the literature** on self-harm, both in prison and in the community, with a particular emphasis on issues surrounding the impact of self-harm on professional working with people who self-harm.
- **Survey of establishments** to gather information about existing sources of staff support, and identify examples of good practice.
- **Qualitative study**: in-depth face-to-face interviews to be carried out with fifteen Prison Officers who are representative of both genders and all grades. The interviews will be semi-structured and will include broad and open questions about staff views, experiences and problems in working with prisoners who self-harm. Further questions will address the ways in which Prison Officers cope with such difficult area of work, and aim to elicit their needs and preferences for support. Where possible, a semi-structured interview will be conducted with the prison Governing Governor, or another Governor, on issues around suicide and self-harm policy and post-incident staff support. All the interviews will be audio-taped.

What data gathering and sampling techniques will be employed?

Please include with this application any research tools such as questionnaires, interview schedules etc... Where data on prisoners is required, details of the information sought should be attached.

A survey of current practices of staff support will be sent to prison establishments across England and Wales, from a contact list to be made available by the Safer Custody Group. As well as providing information about existing sources of staff support, the survey will be used to guide establishment selection (where possible, participants in the proposed interview study will be recruited from the establishment identified as implementing 'best practice').

Within the selected establishment, officer recruitment will be made by a process of refusal. As suggested by Liebling (1992: 133), 'it is rather unrealistic to attempt a strictly random sample of staff, so availability and willingness will have to determine the sample to some extent'. Prison Officers from all ranks, genders and ethnic groups will be approached and invited to take part in the research. Given that 'shift patterns and work commitments in prison render any notion of selecting prison officers for pre-arranged interviews wholly unrealistic' (ibid.), the researcher will approach officers in a direct and informal way, for instance by chatting to officers at wing meetings, or discussing the research with low numbers of staff in the wing office.

Participants will be interviewed in private by the researcher. Staff will be informed that they are not obliged to participate in the research, and that all information collected will be regarded as confidential and anonymous in all written form. The interviews will be audio-taped and will last 45 to 60 minutes.

How will internal and external validity be established?

The proposed study will involve a small sample, in a single prison establishment, and, as such, may be accused of being 'local, specific, and non-generalisable' (May, 1997). However, given the nature of the proposed investigation, issues of generalisability are not of primary concern. Within a qualitative methodological framework (such as the one employed in this study), the term 'validity' refers to the 'correctness or credibility of a description, conclusion, explanation, interpretation, or other sort of account' (Maxwell, 1998: 87). In line with this conceptualisation, it may be argued that achieving validity involves searching for, and seeking to rule out, any 'evidence that challenges one's conclusion(s)' (ibid.). To this aim, the researcher will produce verbatim transcripts from all interviews (in order to generate accurate and complete data), and search for any discrepant data or evidence which may falsify the conclusions or suggests alternative explanations.

Although the findings of the proposed study may be specific to a particular group of prison officers in a particular establishment, they will, nevertheless, be set within broader organisational and institutional structures, and, as such, may well reflect wider themes and issues. This case study should, therefore, have some theoretical and practical relevance for other related areas, groups and settings.

Which (if any) measurement tools will be used?
For a copy of the survey and interview schedules to be employed in this research please refer to Appendix A. (Please note that this version of the staff interview schedule is subject to piloting).

Please list any equipment, which you are intending to bring into the prison establishment.
Tape recorder.

What is the proposed timetable for the research?

Progress to date:	Ongoing review of the literature on suicide and self-harm in prison. Review of the literature on the impact of self-harm on professionals working with self-harm, both in prison and in the community.
Jan 2004	Carry out survey of establishments.
Feb 2004	Negotiate access to participants and pilot interview schedule.
March - April 2004	Fieldwork.
May 2004	Transcribe and analyse interview data.
June - July 2004	Write up final report.

When is the research due to be completed?
Fieldwork: April 2004
Report: July 2004

3. RESEARCH ANALYSIS AND DISSEMINATION

How will the research results be analysed?
All qualitative interviews will be audio-taped, transcribed, coded, and analysed using a thematic approach (see e.g. Banister, Burman, Parker, Taylor and Tindall, 1994; Boyatzis, 1998).

How long will the research materials be retained?
In compliance with the Data Protection Act 1998, the researcher will store data securely, and remove any information that could be directly reconnected to a participant's identity. Raw data will be retained for at least a year from publication.

How will the results of the research be disseminated? (e.g. thesis, article, book etc...). **Indicate how the results will be made available to the Prison Service.**

- MSc dissertation;
- Academic publications.

An interim copy of the report will be made available to the Prison Service in July 2004, whilst the final MSc report will be provided in September 2004.

4. ACCESS TO PRISON ESTABLISHMENTS, PRISONERS AND PRISON STAFF

What establishment is access being sought for (name(s) or type(s) of establishment)?
Participants will be recruited from an HM Prison Service establishment in England and Wales (preferably a young offenders institution or adult male establishment in the London area). The selection process will depend upon the results of the proposed survey of staff support. Where possible, participants will be recruited from the establishment identified as implementing 'best practice'. Further details will be made available at a later date.

Have these establishments (or any others) been approached separately about this research? No

How long will the researcher(s) need to be inside each prison establishment (number of days and numbers of hours a day)?
Approximately ten days, for 4-5 hours a day.

How long will the researcher(s) need to be in contact with prisoners?
The proposed study does not involve contact with prisoners.

How many prisoners would be involved?
None.

Are there any special requirements (random selection, specific prisoner groups etc.)?
All Prison Officers involved in this study must have some experience of working with prisoners who self-harm. The researcher will try to ensure that this requirement is met - by asking participants whether they have ever worked with prisoners who self-harm - when discussing issues around consent, hence prior to the data collection phase.

How long will the researcher(s) need to be in contact with prison staff?
Interviews will last approximately 45 to 60 minutes. Some additional contact time may also be necessary to approach officers to take part in the study. However, the researcher does not, in any way, wish to disrupt the routine of prison staff, and will keep contact with officers to a minimum.

Which type of staff would be involved?
The Governing Governor and a sample of Prison Officers who are representative of both genders and all ranks. Wherever possible, some participants will be drawn from ethnic minority groups.

How many staff would be involved?
Fifteen.

Are there any resource implications for Prison Service Headquarters? (anticipated demands on staff time, office requirements, information etc...)
Demand on staff time: time required to approach officers to take part in the study, and, where applicable, to participate in a 45-60 minute interview.

5. RESEARCH ETHICS

What procedures are there in place to ensure that the consent of inmates will be obtained on a valid and informed basis and that the information will comply with the Data Protection Act? (Attach examples of consent forms)

This research has been approved by the ethics committee at Middlesex University. The researcher will take a number of steps to ensure the ethical acceptability of this study. Care will be taken to explain to participants the purpose, methods, and intended or possible uses of the research. They will also be reminded of their right to decline participation or to discontinue it at any time. Furthermore, participants in this study will be reassured that the researcher will act in strict compliance with the Data Protection Act, 1998 in the collection, processing, storage or destruction of any personal data. All of these points will be explained to participants in an intelligible, sensitive and honest manner, then further elucidated in a consent sheet, which they will be asked to read and sign prior to the data collection phase. In respect of the ethical principles set by the British Psychological Society, participants will be fully debriefed on completion of the study, hence provided with 'any necessary information to complete their understanding of the nature of the research' (BPS Code of Conduct, Ethical Principles and Guidelines, 2000: 8). As part of their debriefing, participants will also be provided with an information sheet with details of various sources of advice and support. A summary of key findings will be sent to all participants, and each wing will receive a copy of the final report, as will the governor of the establishment where the research will be carried out.

Under which ethical guidelines will the research be conducted?
This research will be conducted in compliance with the ethical guidelines of Middlesex University and the British Psychological Society (BPS).

Appendix 1a: Application submitted in relation to the initial research project: "The Impact of Prisoner Self-Harm on Prison Officers: Experiences, reactions and support needs".

Has a relevant Ethics Committee approved the research? Yes
Please attach a copy of the submission to the Ethics Committee and its response:

Signature: **Date:**

Please return this form, together with

- ☐ *Copies of the CVs of all researchers*
- ☐ *Copies of any submission to an Ethics Committee and its response*
- ☐ *Copies of any questionnaires, topic schedules, and consent forms*

to: Charlotte Allen, Research Strategy Team, Prison Service Headquarters, Room 621, Abell House, John Islip Street, SW1P 4LH

NATIONAL PROBATION SERVICE
for England and Wales
National Directorate

HM PRISON SERVICE

Applied Psychology Group

From: David Crighton
Room 310 Cleland House
☎: 020 7217 6890 **FAX**: 020 7217 6879
e-mail: psychologygroup@atlas.co.uk

To: Lisa Marzano
Department of Psychology
University of Middlesex

Cc: Jo Borrill

Date: 6th January 2004

Dear Ms Marzano,

Re: Application to undertake research in HM Prison Service

I have now had the opportunity to consult on and review your submission. I am pleased to be able to support your application subject to the agreement of operational managers at establishment level and subject to the following:

- That the Prison Service receives a copy of the ethical approval for your research from Middlesex University
- That the Prison service receives a copy of the research dissertation and of any published papers based on the research
- Provision of an annual progress summary (if applicable)

During the consultation process Safer Custody Group raised a number of detailed suggestions for possible improvements to your research. I would very much encourage you to contact Dr Jo Borrill the Research Programme Manager to discuss these.

May I take this opportunity to wish you well with your research.

Yonrs sincerely,

David Crighton
Deputy Head of Psychology

Appendix 1c: Governor Recruitment and Follow up Letters

CONTACT LETTER

Middlesex
University

Queensway, Enfield
Middlesex, EN3 4SA
Tel. (+44) 020 8411 6861

Date

Dear (name of Governing Governor),

I am currently conducting a study on the psychological impact of self-harm on prison staff, and I would be most grateful if you would give me permission to contact officers working within your prison about this. This research was designed in consultation with the Safer Custody Group, and has been officially approved by HM Prison Service Applied Psychology Group, as well as by the ethics committee at Middlesex University. This study is funded by the Economic and Social Research Council (ESRC) and will provide material for my postgraduate degree in psychology.

The main purpose of this research is to explore the views and concerns of prison officers working with prisoners who self-harm. This would involve interviewing staff about this issue, as well as exploring their views about how those dealing with self-harming prisoners could best be supported. It would also be very helpful if you, or another governor, would consider taking part in this research. This would provide useful contextual information for my study, and ensure that senior management views are also heard.

I would be interviewing staff individually in a private place for approximately 45 to 60 minutes, using an audio-tape. Participants would be free to stop the interview at any time, would be under no obligation to answer any of the questions, and would be able to withdraw at any time during the research process. All the participants' details would be treated with the strictest confidentiality, any identifying factors would be changed in order that all their answers remain anonymous, and the institution would not be named in any published articles or reports. A report from this study will be passed on to the Safer Custody Group to help with the planning and implementation of staff training modules and support interventions. The Safer Custody Group, however, will not be informed about where this research was carried out, and any identifying factors will be changed in order to ensure that the location remains confidential.

I will telephone you in the next few days in order to discuss this further. If in the meantime you have any questions about this research, please do not hesitate to contact me by e-mail at L.Marzano@mdx.ac.uk or by telephone on 0208 411 6861.

Thank you for considering this matter.

Yours sincerely,

Lisa Marzano

FOLLOW UP LETTERS

Queensway, Enfield
Middlesex, EN3 4SA
Tel. (+44) 020 8411 6861

Date

Dear (name of Governing Governor),

Thank you for giving me permission to contact officers working within your establishment about my research on the psychological impact of self-harm on prison staff. I am now in the process of arranging interviews with staff and should soon be able to start collecting data.

As you may remember, I asked you in my previous letter if you, or another governor, would consider taking part in this research. This would involve being interviewed by myself about the establishment's current suicide and self-harm strategy. This would provide very useful contextual information for my study and ensure that senior management views are heard. The interview would last approximately 45 minutes and would be audio-taped. All of your responses would be completely confidential and any identifying factors would be removed to ensure that your input would be anonymous, and the institution would not be named in any published articles or reports.

Thank you for considering this matter. I will contact you to discuss this by telephone in the next few days. If in the meantime you have any questions about this research, please do not hesitate to contact me by e-mail at L.Marzano@mdx.ac.uk or by telephone on 0208 411 6861.

Yours sincerely,

Lisa Marzano

Middlesex University

Queensway, Enfield
Middlesex, EN3 4SA
Tel. (+44) 020 8411 6861

3rd October 2005

Dear Governor [information withheld to protect participant anonymity],

Thank you very much for giving me permission to contact staff working within your establishment about my research on the psychological impact of self-harm on prison staff, and for personally taking part in this study.

As you may remember, we also discussed the possibility of me conducting some interviews with prisoners at HMP [information withheld to protect participant anonymity]. The main purpose of this study would be to explore the views, motivations and concerns of prisoners who repeatedly self-harm. The interviews would also include questions about participants' experiences of imprisonment, and their relationships with people inside and outside the prison. This study, which is funded by the Economic and Social Research Council (ESRC), has been officially approved by the ethics committee at Middlesex University, and would provide material for my Ph.D. in psychology.

This research would involve interviewing 15 to 20 prisoners individually for approximately one hour, and these interviews would be tape-recorded. Participants would be free to stop the interview at any time, would be under no obligation to answer any of the questions, and would be able to withdraw at any time during the research process. Please note that the institution would not be named in any published articles or reports, and that all the participants' details would be treated with the strictest confidentiality and anonymity, within the limits imposed by the law. Participants would be warned that, should they disclose the intention to commit a crime or cause serious harm to yourself or others, I would be obliged to inform a member of staff. A summary of key findings would be made available to all participants, and the institution would receive a copy of the final research report.

Thank you for considering this matter. I will contact you to discuss this by telephone in the next few days. If in the meantime you have any questions about this research, please do not hesitate to contact me by e-mail at L.Marzano@mdx.ac.uk or by telephone on 0208 411 6861.

Yours sincerely,

Lisa Marzano

Psychology Curriculum Group

REQUEST FOR ETHICAL APPROVAL

No study may proceed until this form has been signed by an authorised person, indicating that ethical approval has been granted.

This form should be accompanied by any other relevant materials, (eg. a copy of the research protocol, questionnaire to be employed, letters to participants/institutions, advertisements or recruiting materials, information sheet for participants[1], consent form[2], or other.)

Name of principal investigator: Lisa Marzano

Name of supervisor/tutor: Dr. Joanna Adler and Dr. Karen Ciclitira

Name(s) of student collaborator(s), if any:

Title of study
The impact of prisoner self-harm on Prison Officers: experiences, reactions and support needs.

1. **Please give a brief description of the nature of the study, including details of the procedure to be employed. Identify the ethical issues involved, particularly in relation to the treatment/experiences of participants, session length, procedures, stimuli, responses, data collection, and the storage and reporting of data.**

The main purpose of the proposed research is to explore the views and concerns of Prison Officers working with prisoners who self-harm, and identify staff needs and preferences for support. This study proposes the following methods:

1. Survey of establishments to gather information about existing sources of support for staff working with self-harm, and identify examples of good practice.

2. Qualitative study: in-depth face-to-face interviews to be carried out with fifteen Prison Officers from all grades. The interviews will be semi-structured and will include broad and open questions about staff views, experiences and problems in working with self-harm. Further questions will address the ways in which staff cope with such a difficult area of work, and aim to elicit their needs and preferences for support. Where possible, a semi-structured interview will be conducted with the prison Governing Governor, or another governor, on issues around suicide and self-harm policy and post-incident staff support. Each interview is expected to last approximately 45 to 60 minutes, and will be audio-taped.

Access to all participants will be negotiated with the Prison Service and the Safer Custody Group, Prison Service HQ. Given the sensitive nature of the proposed investigation, the researcher will take a number of steps to ensure the ethical acceptability of this study. Care will be taken to explain to participants the purpose, methods, and intended or possible uses of the results of this research. Participants will also be reminded of their right to decline participation or to discontinue it at any time. Furthermore, all officers who are to participate in this study will be reassured that the researcher will act in strict compliance with the Data Protection Act, 1998 in the

collection, processing, storage or destruction of any personal data. All of these points will be explained to participants in an intelligible, sensitive and honest manner, then further elucidated in a consent sheet, which they will be asked to read and sign prior to the data collection phase. In respect of the ethical principles set by the British Psychological Society, participants will be fully debriefed on completion of the study, hence provided with 'any necessary information to complete their understanding of the nature of the research' (BPS Code of Conduct, Ethical Principles and Guidelines, 2000: 8). As part of their debriefing, participants will also be provided with an information sheet with details of various sources of advice and support. A summary of key findings will be sent to all participants, and each wing will receive a copy of the final report, as will the governor of the establishment where the research will be carried out.

How does the proposed study contribute to knowledge?
The proposed study aims to increase knowledge about the issues and needs of staff working with prisoners who self-harm. The researcher intends to explore staff experiences, attitudes and problems in working with self-harm, an area which has not been fully investigated before (see e.g. Liebling, 1992; Bailey, McHugh, Chisnall and Forbes, 2002), and, arguably, has important implications for the lives and work of Prison Officers, not least of which for their crucial role in the prevention and management of self-harm in prisons (see e.g. Dexter and Towl, 1995; Power, 1997; Home Office, 1999).

2. Could any of the procedures that you are proposing to adopt result in any adverse reactions? YES

If "yes", what precautionary steps are to be taken?
Please refer to 1.

3. Will any form of deception be involved that raises ethical issues? (Most studies in psychology involve a mild degree of deception insofar as participants are unaware of the experimental hypotheses being tested. Deception becomes unethical if participants are likely to feel angry or humiliated when the deception is revealed to them.)
NO

4. If participants other than Middlesex University students are to be involved, where do you intend to recruit them?
Participants will be recruited from an HM Prison Service establishment in England and Wales (preferably in the London area). The selection process will depend upon the results of the proposed survey of staff support. Where possible, participants will be recruited from the establishment identified as implementing 'best practice'. Further details will be made available at a later date.

5. Does the study involve

Clinical populations	NO
Children (under 16 years)	NO
Vulnerable adults such as individuals with mental health problems, learning disabilities, prisoners, elderly, young offenders?	NO

6. How, and from whom, will informed consent be obtained (see *consent guidelines*[2])?
Written informed consent will be obtained from all participants in the proposed study prior to the data collection phase.

7. **Will you inform participants of their right to withdraw from the research at any time, without penalty** (*see consent guidelines*[2]) YES

8. **Will you provide a full debriefing at the end of the data collection phase** (*see debriefing guidelines*[3]) YES

9. **Will an opportunity exist to discuss the study with the participants to monitor any negative effects or misconceptions?** YES

If "yes", how do you propose to deal with such problems?
Discussion of the study to monitor the possibility of any negative effects or misconceptions will be an important part of the participants' de-briefing (Please refer to 1)

10. **Under the Data Protection Act, information about a participant is confidential unless otherwise agreed in advance. Will confidentiality be guaranteed?** YES

If "yes", how will this be assured? If "no", how will participants be warned?
Confidentiality will be maintained when analysing, writing up, disseminating and storing questionnaire and interview data. Furthermore, care will be taken to ensure that any information that could be directly reconnected to a participant's identity is changed.

(NB: You are not at liberty to publish material taken from your work with individuals without the prior agreement of those individuals).

11. **Are there any ethical issues which concern you about this particular piece of research, not covered elsewhere on this form?** YES

If "yes" please specify:

(NB: If "yes" has been responded to any of questions 2,3,5,11 or "no" to any of questions 7-10, a full explanation of the reason should be provided on a separate sheet, and submitted with this form).

I have read the British Psychological Society's *Ethical Principles for Conducting Research with Human participants* and believe this proposal to conform with them.

Researcher ..... date 1/12/03

Signatures of approval:

Supervisor ..... date 2-12-3

Ethics Committee ..... date 15-12-03
(approval granted for the study to proceed)

N.B. Her supervisor is Karen Cochrane so do not pass to her for vetting.

ETHICAL ISSUES

Ethical issues inevitably arise when conducting research with human participants. This is especially true when investigating a topic as sensitive as prisoner self-harm. Interviewing staff about their experiences with prisoners who harm themselves raises a number of ethical concerns, the most significant of which will be briefly outlined below.

In the prison environment, staff are those who most often discover and deal with self-injury. Prison Officers witness enormous physical and emotional pain, which may leave them feeling shocked, upset and angry, and may remind them of their own sadness and distress (Arnold and Magill, 1996). Staff themselves may self-harm, or may be close to someone who does, which raises important ethical questions for interviewing Prison Officers about this sensitive topic. When poorly trained or working with inadequate models of self-harm, Prison Officers may be especially reluctant to discuss this difficult area of work, as they may feel 'unsure, inadequate, unqualified, or even useless' (Arnold, 1995: 22). Furthermore, 'the staff's professional role often makes the direct expression of their emotions questionable and professionalism may prohibit such expression' (Norton and Dolan, 1995: 77). This may signify that staff will feel uncomfortable in sharing with the researcher their genuine emotional reactions to people who self-injure, and may prove to be rather cautious participants in the research process.

In view of the recent politicisation of self-harm in prisons, the ethical dilemmas involved in interviewing prison staff on this subject are now greater than ever before. Reducing the incidence of suicide and self-harm was recently identified as *the* 'top priority' for the Prison Service (Home Office, 1999). Being actively involved in the identification and management of prisoners at risk of suicide/self-harm, staff are currently under enormous pressure, and are having to deal with issues of responsibility and accountability like never before. As argued by the Howard League (2003: 12), '[in an environment] in which the success of their work is measured by a reduction in the number of incidents of self-injury ... the value of their work in the face of continued self-injury is not recognised, and staff are liable to take the emotional blame for continued self-injury'. In the context of this 'performance culture' (Liebling and Price, 2001), Prison Officers may feel 'under accusation', and hence prove to be rather cautious and reluctant participants in the research process. This is also likely to be true of the Prison Governing Governor. Having 'overall responsibility for the implementation of suicide and self-harm prevention policy procedures within their establishment' (Prison Service Order 2700, para. 1.4.1) he/she may feel particularly anxious about the intrusion of an outsider, and the picture that the researcher will carry to the outside world.

In the course of the proposed study, the researcher may touch upon a variety of difficult and emotional topics, which, commonsensically, raises a whole range of ethical issues. Nevertheless, there is evidence that disclosing about difficult areas of one's life is frequently accompanied by a sense of relief and catharsis (see e.g. Liebling, 1992). Arguably, sharing difficult and uncomfortable emotions with the researcher may offer participants an opportunity for discharging angry, sad, or anxious feelings, or reducing a sense of shame or guilt.

Furthermore, given that '[prison] staff attitudes, experiences and problems are usually overlooked' (Liebling, 1992: 195), and that Prison Officers feel generally devalued and under regarded (see e.g. Narey, 2001; Liebling and Price, 2001; Lyon, 2003), it may be unethical *not* to explore their views and concerns about working with prisoners who self-harm. Notwithstanding the very sensitive nature of this topic, it may be suggested that interviewing staff about prisoner self-harm may give them a sense of recognition and appreciation for the stresses and difficulties involved in this area of work.

As suggested by Renzetti and Lee (1993, p. 9) 'research on sensitive topics may produce not only gains in knowledge but also affects that are directly beneficial to research participants'. Provided that ethically sound procedures and precautions are in place (please refer to section 1), *sensitive* research does not have to be *unethical* research.

REFERENCES

Arnold, L. (1995, September) *'Ways forward: meeting the needs of women who self-injure'.* Speech presented at the National Conference on Self-injury, Bristol, UK.

Arnold, L., and Magill, A. (1996) *Working with Self-Injury: A practical Guide.* Bristol: The Basement Project.

Bailey, J., McHugh, M., Chisnall, L. and Forbes, D. (2002) *Training staff in suicide awareness.* In Towl, G., Snow, L., and McHugh, M. (eds) (2002) *Suicide in Prisons.* Oxford: Blackwell Publishers.

Dexter, P.M. and Towl, G. (1995) *An investigation into suicidal behaviours in prison.* In Clark, N.K and Stephenson, G.M. (eds) (1997) *Criminal Behaviour: Perceptions, Attributions, and Rationality.* Leicester: The British Psychological Society.

HM Prison Service (2002) *Prison Service Order 2700 Suicide and Self-Harm Prevention - Issue No 160, 4 November 2002.* London: HM Prison Service.

Home Office (1999) *Suicide is Everyone's Concern: A Thematic Review by HM Chief Inspector Of Prisons for England and Wales.* London: HMSO.

Howard League For Penal Reform (2003) *Suicide and Self-Harm Prevention: The Management of Self-Injury in Prisons.* London: The Howard League.

Liebling, A. (1992) *Suicides in Prison.* London: Routledge.

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Lyon, J. (2003) Managing to Work in Prisons. *Prison Report,* **61**: 3.

Narey, M. (2001) *Foreword by the Director General of the Prison Service: The Prison Officer.* In Liebling, A. and Price, D. (2001) *The Prison Officer.* Winchester: Waterside Press.

Norton, K. And Dolan, B. (1995) Acting Out and the Institutional Response. *Journal of Forensic Psychiatry,* **6**: 317-322.

Power, K.G. (1997) *Evaluation of the Scottish Prison Service Suicide Prevention Strategy.* Edinburgh: Scottish Prison Service.

Psychology Curriculum Group

REQUEST FOR ETHICAL APPROVAL

No study may proceed until this form has been signed by an authorised person, indicating that ethical approval has been granted.

This form should be accompanied by any other relevant materials, (eg. a copy of the research protocol, questionnaire to be employed, letters to participants/institutions, advertisements or recruiting materials, information sheet for participants[1], consent form[2], or other.)

Name of principal investigator: Lisa Marzano

Name of supervisor/tutor: Dr. Joanna Adler and Dr. Karen Ciclitira

Name(s) of student collaborator(s), if any:

Title of study
The impact of prisoner self-harm on Prison Nurses: experiences, reactions and support needs.

1. **Please give a brief description of the nature of the study, including details of the procedure to be employed. Identify the ethical issues involved, particularly in relation to the treatment/experiences of participants, session length, procedures, stimuli, responses, data collection, and the storage and reporting of data.**

The main purpose of the proposed research is to explore the views and concerns of Prison Nurses working with prisoners who self-harm. In-depth face-to-face interviews will be carried out with fifteen Prison Nurses from all grades and departments. The interviews will be semi-structured and will include broad and open questions about participants' views, experiences and problems in working with self-harm. Further questions will address the ways in which nurses cope with such a difficult area of work, and aim to elicit their needs and preferences for support. Each interview is expected to last approximately 45 minutes, and will be audio-taped.

Access to all participants will be negotiated with the Prison Service. Given the sensitive nature of the proposed investigation, the researcher will take a number of steps to ensure the ethical acceptability of this study. Care will be taken to explain to participants the purpose, methods, and intended or possible uses of the results of this research. Participants will also be reminded of their right to decline participation or to discontinue it at any time. Furthermore, all nurses who are to participate in this study will be reassured that the researcher will act in strict compliance with the Data Protection Act, 1998 in the collection, processing, storage or destruction of any personal data. All of these points will be explained to participants in an intelligible, sensitive and honest manner, then further elucidated in a consent sheet, which they will be asked to read prior to the data collection phase. In respect of the ethical principles set by the British Psychological Society, participants will be fully debriefed on completion of the study, hence provided with 'any necessary information to complete their understanding of the nature of the research' (BPS Code of Conduct, Ethical

Principles and Guidelines, 2000: 8). As part of their debriefing, participants will also be provided with an information sheet with details of various sources of advice and support. A summary of key findings will be made available to all participants. Each wing will receive a copy of the research report, as will the governor of the establishment where the research will be carried out.

How does the proposed study contribute to knowledge?
The proposed study aims to increase knowledge about the issues and needs of prison nurses working with prisoners who self-harm. The researcher intends to explore nurses' experiences, attitudes and problems in working with self-harm, an area which has not been fully investigated before, and, arguably, has important implications for the prevention and management of self-harm in prisons.

2. Could any of the procedures that you are proposing to adopt result in any adverse reactions? YES

If "yes", what precautionary steps are to be taken?
Please refer to 1.

3. Will any form of deception be involved that raises ethical issues? (Most studies in psychology involve a mild degree of deception insofar as participants are unaware of the experimental hypotheses being tested. Deception becomes unethical if participants are likely to feel angry or humiliated when the deception is revealed to them). NO

4. If participants other than Middlesex University students are to be involved, where do you intend to recruit them?
Participants will be recruited from an adult male HM Prison Service establishment in London.

5. Does the study involve

Clinical populations	NO
Children (under 16 years)	NO
Vulnerable adults such as individuals with mental health problems, learning disabilities, prisoners, elderly, young offenders?	NO

6. How, and from whom, will informed consent be obtained (see *consent guidelines*[2])?
Written informed consent will be obtained from all participants in the proposed study prior to the data collection phase.

7. **Will you inform participants of their right to withdraw from the research at any time, without penalty** (*see consent guidelines*[2]) YES

8. **Will you provide a full debriefing at the end of the data collection phase** (*see debriefing guidelines*[3]) YES

9. **Will an opportunity exist to discuss the study with the participants to monitor any negative effects or misconceptions?** YES

If "yes", how do you propose to deal with such problems?
Discussion of the study to monitor the possibility of any negative effects or misconceptions will be an important part of the participants' de-briefing (Please refer to section 1)

10. **Under the Data Protection Act, information about a participant is confidential unless otherwise agreed in advance. Will confidentiality be guaranteed?** YES

If "yes", how will this be assured? If "no", how will participants be warned?
Confidentiality will be maintained when analysing, writing up, disseminating and storing interview data. Furthermore, care will be taken to ensure that any information that could be directly reconnected to a participant's identity is changed.

(NB: You are not at liberty to publish material taken from your work with individuals without the prior agreement of those individuals).

11. **Are there any ethical issues which concern you about this particular piece of research, not covered elsewhere on this form?** NO

If "yes" please specify:

(NB: If "yes" has been responded to any of questions 2,3,5,11 or "no" to any of questions 7-10, a full explanation of the reason should be provided on a separate sheet, and submitted with this form).

I have read the British Psychological Society's *Ethical Principles for Conducting Research with Human participants*[4] and believe this proposal to conform with them.

Researcher ..... date 24/10/05

Signatures of approval:

Supervisor ..... date 24/10/05

Ethics Committee ..... date 25:10:05
(approval granted for the study to proceed)

ETHICAL ISSUES

Ethical issues inevitably arise when conducting research with human participants. This is especially the case when investigating a sensitive and politicised topic like self-harm in prisons. Interviewing prison nurses about their experiences with prisoners who harm themselves raises a number of ethical concerns, the most significant of which will be briefly outlined below.

In the prison environment, nurses are those who treat prisoners' self-inflicted injuries. This can mean witnessing enormous physical and emotional pain, which may leave nurses feeling shocked, upset and angry, and may remind them of their own sadness and distress (Arnold and Magill, 1996). Staff themselves may self-harm, or may be close to someone who does, which raises important ethical questions for interviewing prison nurses about this sensitive topic. When poorly trained or working with inadequate models of self-harm, participants may be especially reluctant to discuss this difficult area of work, as they may feel 'unsure, inadequate, unqualified, or even useless' (Arnold, 1995: 22). Furthermore, 'the staff's professional role often makes the direct expression of their emotions questionable and professionalism may prohibit such expression' (Norton and Dolan, 1995: 77). This may signify that nurses will feel uncomfortable in sharing with the researcher their genuine emotional reactions to people who self-injure, and may prove to be rather cautious participants in the research process. As a result, the researcher will take special care to ensure the ethical acceptability of the proposed study, and to act in strict compliance with the ethical guidelines set out by Middlesex University and the British Psychological Society.

Notwithstanding the sensitive nature of this topic, it may be suggested that interviewing nurses about prisoner self-harm may give them a sense of recognition and appreciation for the stresses and difficulties involved in this area of work. As suggested by Renzetti and Lee (1993, p. 9) 'research on sensitive topics may produce not only gains in knowledge but also affects that are directly beneficial to research participants'. Provided that ethically sound procedures and precautions are in place (please refer to section 1), *sensitive* research does not have to be *unethical* research.

References

Arnold, L. (1995, September). *'Ways forward: meeting the needs of women who self-injure'*. Speech presented at the National Conference on Self-injury, Bristol, UK.

Arnold, L., and Magill, A. (1996). *Working with Self-Injury: A practical Guide.* Bristol: The Basement Project.

Norton, K. And Dolan, B. (1995). Acting Out and the Institutional Response. *Journal of Forensic Psychiatry*, **6**: 317-322.

Renzetti, C.M. and Lee, R.M. (Eds) (1993). *Researching Sensitive Topics.* London: Sage Publications.

Psychology Curriculum Group

REQUEST FOR ETHICAL APPROVAL

No study may proceed until this form has been signed by an authorised person, indicating that ethical approval has been granted.

This form should be accompanied by any other relevant materials, (e.g. a copy of the research protocol, questionnaire to be employed, letters to participants/institutions, advertisements or recruiting materials, information sheet for participants[1], consent form[2], or other.)

Name of principal investigator: Lisa Marzano

Name of supervisor/tutor: Dr. Joanna Adler and Dr. Karen Ciclitira

Name(s) of student collaborator(s), if any:

Title of study
Working title: 'Prolific self-harm' in custody: experiences, motivations, and needs of adult male prisoners who repeatedly self-harm, with no suicidal intent.

1. **Please give a brief description of the nature of the study, including details of the procedure to be employed. Identify the ethical issues involved, particularly in relation to the treatment/experiences of participants, session length, procedures, stimuli, responses, data collection, and the storage and reporting of data.**

The proposed research is concerned with the welfare and motivations of prisoners who repeatedly self-harm, with no apparent suicidal intent. Semi-structured face-to-face interviews will be carried out with 15 to 20 prisoners from an adult male local prison, on issues concerning their experiences of imprisonment and their self-harming behaviour. The interviews will also aim to investigate the effects of staff attitudes and reactions to self-harm on the quality of staff-prisoner relationships, and their potential implications for rates of suicide and self-harm in custody.

Each interview is expected to last approximately 60 minutes, and will be audio-taped. Access to all participants will be negotiated with the Prison Service and the Safer Custody Group, Prison Service HQ. Given the sensitive nature of the proposed investigation, the researcher will take a number of steps to ensure the ethical acceptability of this study. Care will be taken to explain to participants the purpose, methods, and intended or possible uses of the results of this research. Participants will also be reminded of their right to decline participation or to discontinue it at any time. Furthermore, all prisoners who are to participate in this study will be reassured that the researcher will act in strict compliance with the Data Protection Act, 1998 in the collection, processing, storage or destruction of any personal data. All of these points will be explained to participants in an intelligible, sensitive and honest manner, then further elucidated in a consent sheet, which they will be asked to read and sign prior to the data collection phase. In respect of the ethical principles set by the British Psychological Society, participants will be fully debriefed on completion of the study,

hence provided with 'any necessary information to complete their understanding of the nature of the research' (BPS Code of Conduct, Ethical Principles and Guidelines, 2000: 8). As part of their debriefing, participants will also be provided with an information sheet with details of various sources of advice and support. A summary of key findings will be made available to all participants. Each wing will receive a copy of the research report, as will the governor of the establishment where the research will be carried out.

How does the proposed study contribute to knowledge?
The proposed study aims to increase knowledge and awareness about the needs and motivations of prisoners who self-harm with no apparent suicidal intent. As argued by Clarke and Whittaker (1998, p. 129), 'this [form of behaviour] appears to be the least understood, receives the least attention from researchers and yet remains a very complex, mismanaged and somewhat isolated aspect of mental health'.

2. Conld any of the procedures that you are proposing to adopt result in any adverse reactions? YES

If "yes", what precautionary steps are to be taken?
Please refer to 1.

3. Will any form of deception be involved that raises ethical issues? (Most studies in psychology involve a mild degree of deception insofar as participants are unaware of the experimental hypotheses being tested. Deception becomes unethical if participants are likely to feel angry or humiliated when the deception is revealed to them.) NO

4. If participants other than Middlesex University students are to be involved, where do you intend to recruit them?
Participants will be recruited from an adult male HM Prison Service establishment in London.

5. Does the study involve

Clinical populations	NO
Children (under 16 years)	NO
Vulnerable adults such as individuals with mental health problems, learning disabilities, prisoners, elderly, young offenders?	YES

6. How, and from whom, will informed consent be obtained (see *consent guidelines*[2])?
Written informed consent will be obtained from all participants in the proposed study prior to the data collection phase. At the end of the interview, participants will also be asked to consent to the researcher accessing their files, to find out more information about their personal backgrounds and previous convictions. The researcher will not consult prisoners' files without their written informed consent.

7. Will you inform participants of their right to withdraw from the research at any time, without penalty *(see consent guidelines[2])* YES

8. Will you provide a full debriefing at the end of the data collection phase

(*see debriefing guidelines*[3]) YES

9. **Will an opportunity exist to discuss the study with the participants to monitor any negative effects or misconceptions?** YES

If "yes", how do you propose to deal with such problems?
Discussion of the study to monitor the possibility of any negative effects or misconceptions will be an important part of the participants' de-briefing (Please refer to section 1)

10. **Under the Data Protection Act, information about a participant is confidential unless otherwise agreed in advance. Will confidentiality be guaranteed?** Limited Confidentiality will be assured.

If "yes", how will this be assured? If "no", how will participants be warned?
Confidentiality will be maintained when analysing, writing up, disseminating and storing questionnaire and interview data. Furthermore, care will be taken to ensure that any information that could be directly reconnected to a participant's identity is removed. However, given that this is prison based research, participants will also be warned prior to being asked for consent of the possibility of disclosure (with or without their consent) if compelled by law. Given the nature of the proposed research, there is a relatively high chance that some participants may reveal suicidal tendencies and/or disclose the intention to self-harm. Where suicide or self-injury seems to be particularly likely and not already known to staff, then the researcher will alert a member of staff. Nonetheless, 'the information disclosed will be sufficient to allow those attempting to protect the participant to do so in a properly informed manner' (Francis, 1999: 219).

(NB: You are not at liberty to publish material taken from your work with individuals without the prior agreement of those individuals).

11. **Are there any ethical issues which concern you about this particular piece of research, not covered elsewhere on this form?** No

If "yes" please specify:

(NB: If "yes" has been responded to any of questions 2,3,5,11 or "no" to any of questions 7-10, a full explanation of the reason should he provided on a separate sheet, and submitted with this form).

I have read the British Psychological Society's *Ethical Principles for Conducting Research with Human participants*[4] and believe this proposal to conform with them.

Researcher..... date ...4/10/05

Signatures of approval:

Supervisor..... date 4/10/05

Ethics Committee..... date ..6/10/05

(approval granted for the study to proceed)

ETHICAL ISSUES

Ethical issues inevitably arise when conducting research with human participants. This is especially the case when investigating a sensitive and politicised topic like self-harm in prisons. Participants will be asked to answer some very personal and potentially difficult questions, which raises a number of ethical issues. Questions about self-harm and suicide attempts are especially likely to leave participants feeling distressed. Interviewing prisoners about their relationships with staff may also cause them some anxiety or discomfort. Previous research has shown that the (often negative) attitudes of staff are frequently perceived by prisoners who self-harm, as one of the most unhelpful aspects of prison life (e.g. Scottish Prison Service, 1997), and may, at times, act as a trigger for further, and more severe, self-injurious behaviour (e.g. Dexter and Towl, 1995). As a result, the researcher will take special care to ensure the ethical acceptability of the proposed study, and to act in strict compliance with the ethical guidelines set out by Middlesex University and the British Psychological Society.

REFERENCES

Clarke, L., and Whittaker, M. (1998) Self-mutilation: Culture, context and nursing. *Journal of Clinical Nursing*, 7, 129-139.

Dexter, P.M. and Towl, G. (1995) *An investigation into suicidal behaviours in prison.* In Clark, N.K and Stephenson, G.M. (eds) (1997) *Criminal Behaviour: Perceptions, Attributions, and Rationality.* Leicester: The British Psychological Society.

Scottish Prison Service (1997) *HMPI Corton Vale: Research into Drugs and Alcohol, Violence and Bullying, Suicides and Self-injury and Backgrounds of Abuse.* Scottish Service Occasional Papers, Report No 1/98.

INDEPENDENT FIELD/LOCATION WORK RISK ASSESSMENT FRA

This proforma is applicable to, and must be completed in advance for, the following fieldwork situations:

1. *All fieldwork undertaken independently by individuol students, either in the UK or overseas, including in connection with proposition module or dissertations. Supervisor to complete with student(s).*
2. *All fieldwork undertaken by postgraduate students. Supervisors to complete with student(s).*
3. *Fieldwork undertaken by research students. Student to complete with supervisor.*
4. *Fieldwork/visits by research staff. Researcher to complete with Research Centre Heod.*

FIELDWORK DETAILS

Name Lisa Marzano

Student No
Research Centre (staff ooly).....

Supervisor Dr. Joanna Adler and Dr. Karen Ciclitira

Degree course MSc Social Science Research Methods

Telephone numbers and name of next of kin who may be contacted in the event of an accident

NEXT OF KIN

Name Patrick Hanna

Phone [redacted]

Physical or psychological limitations to carrying out the proposed fieldwork

None

Any health problems (full details) Which may be relevant to proposed fieldwork activity in case of emergencies.

None

Locality (Country and Region)

HM Prisoo Service Establishment in the London area (further details will be made available at a later date)

Travel Arrangements

Public or private transport, depending on exact fieldwork location.

Comprehensive travel and health insurance must always be obtained for dependent overseas fieldwork.

Dates of Travel and Fieldwork

January to March 2004

PLEASE READ THE INFORMATION OVERLEAF VERY CAREFULLY

Hazard Identification and Risk Assessment

PLEASE READ VERY CAREFULLY

List the localities to be visited or specify routes to be followed (Col. 1). Give the approximate date (month / year) of your last visit, o enter 'NOT VISITED' (Col 2). For each locality, enter the potential hazards that may be identified beyood those accepted in everyday life. Add details giving cause for concern (Col. 3).

Examples of Potential Hazards :

Adverse weather: exposure (heat, sunburn, lightening, wind, hypothermia)
Terrain: rugged, unstable, fall, slip, trip, debris, and remoteness. Traffic: pollution.
Demolition/building sites, assault, getting lost, animals, disease.
Working on/near water: drowning, swept away, disease (weils disease, hepatitis, malaria, etc), parasites', flooding, tides and range.
Lone working: difficult to summon help, alone or in isolation, lone interviews.
Dealing with the public: personal attack, causing offence/intrusion, misinterpreted, political, ethnic, cultural, socio-economic differences/problems. Known or suspected criminal offenders.
Safety Standards (other work organisations, transport, hotels, etc), working at night, areas of high crime.
Ill health: personal considerations or vulnerabilities, pre-determined medical conditions (asthma, allergies, fitting) general fitness, disabilities, persons suited to task.
Articles and equipment: inappropriate type and/or use, failure of equipment, insufficient training for use and repair, injury.
Substances (chemicals, plants, bio- hazards, waste): ill health - poisoning, infection, irritation, burns, cuts, eye-damage.
Manual handling: lifting, carrying, moving large or heavy items, physical unsuitability for task

If no hazard can be identified beyond those of everyday life, enter 'NONE'.

Give brief details of fieldwork activity:

The researcher inteads to conduct in-depth face to face interviews with the Governing Governor and 15 Prison officers and of an HM Prison Service Establishment in England and Wales (preferably in the London area). The focus of the interviews will be 'the psychological impact of prisoner self-harm on Prison Officers: experiences, reaction and support needs'.

1. LOCALITY/ROUTE	2. LAST VISIT	3. POTENTIAL HAZARDS
HM Prison Service Establishment Please note that interviews will only be conducted with members of prison staff. The researcher will not be dealing with prisoners or going into prisoners' cells.	NOT VISITED	Lone interviews (e.g. difficult to summon help) Dealing with the public: risk of unwillingly causing offence/intrusion or being misinterpreted; potential political, ethnic, cultural, socio-economic differences/ problems.

The University Fieldwork code of Practice booklet provides practical advice that should be followed in planning and conducting fieldwork.

Risk Minimisation/Control Measures

PLEASE READ VERY CAREFULLY

For each hazard identified (Col 3), list the precautions/control measures in place or that will be taken (Col 4) to "reduce the risk to acceptable levels", and the safety equipment (Col 6) that will be employed.

Assuming the safety precautions/control methods that will be adopted (Col. 4), categorise the fieldwork risk for each location/route as negligible, low, moderate or high (Col. 5).

Risk increases with both the increasing likelihood of an accident and the increasing severity of the consequences of an accident.

An acceptable level of risk is: a risk which can be safely controlled by person taking part in the activity using the precautions and control measures noted including the necessary instructions, information and training relevant to that risk. The resultant risk should not be significantly higher than that encountered in everyday life.

Examples of control measures/precautions:

Providing adequate training, information & instructions on fieldwork tasks and the safe and correct use of any equipment, substances and personal protective equipment. Inspection and safety check of any equipment prior to use. Assessing individuals fitness and suitability to environment and tasks involved. Appropriate clothing, environmental information consulted and advice followed (weather conditions, tide times etc.). Seek advice on harmful plants, animals & substances that may be encountered, including information and instruction on safe procedures for handling hazardous substances. First aid provisions, inoculations, individual medical requirements, logging of location, route and expected return times of lone workers. Establish emergency procedures (means of raising an alarm, back up arrangements). Working with colleagues (pairs). **Lone working is not permitted where the risk of physical or verbal violence is a realistic possibility.** Training in interview techniques and avoiding /defusing conflict, following advice from local organisations, wearing of clothing unlikely to cause offence or unwanted attention. Interviews in neutral locations. Checks on Health and Safety standards & welfare facilities of travel, accommodation and outside organisations. Seek information on social/cultural/political status of fieldwork area.

Examples of Safety Equipment: Hardhats, goggles, gloves, harness, waders, whistles, boots, mobile phone, ear protectors, bright fluorescent clothing (for roadside work), dust mask, etc.

a proposed locality has not been visited previously, give your authority for the risk assessment stated or indicate that your visit will preceded by a thorough risk assessment.

4. PRECAUTIONS/CONTROL MEASURES	5. RISK ASSESSMENT	6. EQUIPMENT
Safety knowledge and training. Knowledge of and training in HM Prison Service Health and Safety policy and procedures. Training in interview techniques. Awareness of cultural, social, political and ethnic differences. Strict compliance with the British Psychological Society's 'Ethical Principles for Conducting Research with Human Participants'. Carrying out interviews in designated interview rooms. Positioning myself next to alarm bells when conducting interviews.	Low	Suitable clothing (i.e. wearing of clothing unlikely to cause offence or unwanted attention)

INDEPENDENT FIELD/LOCATION WORK RISK ASSESSMENT FRA1

This proformo is applicable to, and must be completed in advance for, the following fieldwork situations:

1. *All fieldwork undertaken independently by individual students, either in the UK or overseos, including in connection with proposition module or dissertations. Supervisor to complete with student(s).*
2. *All fieldwork undertaken by postgraduate students. Supervisors to complete with student(s).*
3. *Fieldwork undertaken by research students. Student to complete with supervisor.*
4. *Fieldwork/visits by research staff. Researcher to complete with Research Centre Head.*

FIELDWORK DETAILS

Name Lisa Marzano

Studeot No
Research Centre (staff only).....

Supervisor Dr. J. Adler and Dr. K. Ciclitira

Degree course MPhil/PhD Psychology

'elephone numbers and name of next of
-- who may be contacted in the event of
.ccident

NEXT OF KIN

Name Patrick Hanna

Phone 0[redacted]

ysical or psychological limitations to
rying out the proposed fieldwork

None

health problems (full details)
:h may be relevant to proposed
vork activity in case of emergencies.

Nooe

ity (Country and Region)

[redacted]

'rangements

Public transport.

iprehensive travel and health
: must always be obtained for
:nt overseas fieldwork.

Travel and Fieldwork

October 2005 to January 2006

READ THE INFORMATION OVERLEAF VERY CAREFULLY

Hazard Identification and Risk Assessment

PLEASE READ VERY CAREFULLY

List the localities to be visited or specify routes to be followed (**Col. 1**). Give the approximate date (month / year) of your last visit, or enter 'NOT VISITED' (**Col 2**). For each locality, enter the potential hazards that may be identified beyond those accepted in everyday life. Add details giving cause for concern (**Col. 3**).

Examples of Potential Hazards :
Adverse weather: exposure (heat, sunburn, lightening, wind, hypothermia)
Terrain: rugged, unstable, fall, slip, trip, debris, and remoteness. Traffic: pollution.
Demolition/building sites, assault, getting lost, animals, disease.
Working on/near water: drowning, swept away, disease (weils disease, hepatitis, malaria, etc), parasites', flooding, tides and range.
Lone working: difficult to summon help, alone or in isolation, lone interviews.
Dealing with the public: personal attack, causing offence/intrusion, misinterpreted, political, ethnic, cultural, socio-economic differences/problems. Known or suspected criminal offenders.
Safety Standards (other work organisations, transport, hotels, etc), working at night, areas of high crime.
Ill health: personal considerations or vulnerabilities, pre-determined medical conditions (asthma, allergies, fitting) general fitness, disabilities, persons suited to task.
Articles and equipment: inappropriate type and/or use, failure of equipment, insufficient training for use and repair, injury.
Substances (chemicals, plants, bio- hazards, waste): ill health - poisoning, infection, irritation, burns, cuts, eye-damage.
Manual handling: lifting, carrying, moving large or heavy items, physical unsuitability for task
no hazard can be identified beyond those of everyday life, enter 'NONE'.

ive brief details of fieldwork activity:

e researcher intends to conduct in-depth face to face interviews with 15 Prison Nurses. The main purpose of the interviews will to explore the views and concerns of Nurses working with prisoners who self-harm, and to identify their needs and preferences support.

LOCALITY/ROUTE	2. LAST VISIT	3. POTENTIAL HAZARDS
Prison Service blishment se note that views will only be ucted with members son staff. The 'cher will not be g with prisoners or into prisoners' is part of this study.	October 2005	Lone interviews (e.g. difficult to summon help) Dealing with the public: risk of unwillingly causing offence/intrusion or being misinterpreted; potential political, ethnic, cultural, socio-economic differences/ problems.

'ersity Fieldwork code of Practice booklet provides practical advice that should be followed in and conducting fieldwork.

Risk Minimisation/Control Measures

PLEASE READ VERY CAREFULLY

For each hazard identified (Col 3), list the precautions/control measures in place or that will be taken (Col 4) to "**reduce the risk to acceptable levels**", and the safety equipment (Col 6) that will be employed.

Assuming the safety precautions/control methods that will be adopted (Col. 4), categorise the fieldwork risk for each location/route as negligible, low, moderate or high (Col. 5).

Risk increases with both the increasing likelihood of an accident and the increasing severity of the consequences of an accident.

An acceptable level of risk is: a risk which can be safely controlled by person taking part in the activity using the precautions and control measures noted including the necessary instructions, information and training relevant to that risk. The resultant risk should not be significantly higher than that encountered in everyday life.

Examples of control measures/precautions:

Providing adequate training, information & instructions on fieldwork tasks and the safe and correct use of any equipment, substances and personal protective equipment. Inspection and safety check of any equipment prior to use. Assessing individuals fitness and suitability to environment and tasks involved. Appropriate clothing, environmental information consulted and advice followed (weather conditions, tide times etc.). Seek advice on harmful plants, animals & substances that may be encountered, including information and instruction on safe procedures for handling hazardous substances. First aid provisions, inoculations, individual medical requirements, logging of location, route and expected return times of lone workers. Establish emergency procedures (means of raising an alarm, back up arrangements). Working with colleagues (pairs). **Lone working is not permitted where the risk of physical or verbal violence is a realistic possibility.** Training in interview techniques and avoiding /defusing conflict, following advice from local organisations, wearing of clothing unlikely to cause offence or unwanted attention. Interviews neutral locations. Checks on Health and Safety standards & welfare facilities of travel, accommodation and outside organisations. Seek information on social/cultural/political status of fieldwork area.

Examples of Safety Equipment: Hardhats, goggles, gloves, harness, waders, whistles, boots, mobile phone, ear protectors, bright fluorescent clothing (for roadside work), dust mask, etc.

proposed locality has not been visited previously, give your authority for the risk assessment stated or indicate that your visit will preceded by a thorough risk assessment.

4. PRECAUTIONS/CONTROL MEASURES	5. RISK ASSESSMENT	6. EQUIPMENT
afety knowledge and training. owledge of and training in HM Prison Service Health and Safety licy and procedures. eping staff informed of my location within the prison at all times. ining in interview techniques. reness of cultural, social, political and ethnic differences. t compliance with the ethical guidelines set out by Middlesex ersity and the British Psychological Society.	Low	Suitable clothing (i.e. wearing of clothing unlikely to cause offence or unwanted attention) Whistle provided by HM Prison Service (to be worn at all times).

EAD INFORMATION OVERLEAF AND SIGN AS APPROPRIATE

DECLARATION: The undersigned have assessed the activity and the associated risks and declare that there is no significant risk or that the risk will be controlled by the method(s) listed above/over. Those participating in the work have read the assessment and will put in place precautions/control measures identified.

NB: Risk should be constantly reassessed during the fieldwork period and additional precautions taken or fieldwork discontinued if the risk is seen to be unacceptable.

Signature of Fieldworker (Student/Staff)	.....	**Date**	24/10/05
Signature of Student Supervisor	.....	**Date**	24/10/05

APPROVAL: (ONE ONLY)

Signature of Curriculum Leader (undergraduate students only)	.....	**Date**	25.10.05
Signature of Research Degree Co-ordinator or Masters Course Leader or Taught Masters Curriculum Leader	.....	**Date**	.....
Signature of Research Centre Head (for staff fieldworkers)	.....	**Date**	.....

FIELDWORK CHECK LIST

Ensure that **all members** of the field party possess the following attributes (where relevant) at a level appropriate to the proposed activity and likely field conditions:

Safety knowledge and training?

Awareness of cultural, social and political differences?

Physical and psychological fitness and disease immunity, protection and awareness?

Personal clothing and safety equipment?

Suitability of fieldworkers to proposed tasks?

ve all the necessary arrangements been made and information/instruction gained, and have the relevant authorities been ted or informed with regard to:

Visa, permits?

egal access to sites and/or persons?

.tical or military sensitivity of the proposed topic, its method or location?

'eather conditions, tide times and ranges?

iccinations and other health precautions?

'il unrest and terrorism?

ival times after journeys?

:y equipment and protective clothing?

ncial and insurance implications?

e risk?

h insurance arrangements?

gency procedures?

t use?

ccommodation arrangements?

rmation for retaining evidence of completed risk assessments: Once the risk assessment is pproval gained the **supervisor** should retain this form and issue a copy of it to the fieldworker he field course/work. In addition the **approver** must keep a copy of this risk assessment in an lth and Safety file.

INDEPENDENT FIELD/LOCATION WORK RISK ASSESSMENT FRA1

This proforma is applicable to, and must be completed in advance for, the following fieldwork situations:

1. *All fieldwork undertaken independently by individual students, either in the UK or overseas, including in connection with proposition module or dissertations. Supervisor to complete with student(s).*
2. *All fieldwork undertaken by postgraduate students. Supervisors to complete with student(s).*
3. *Fieldwork undertaken by research students. Student to complete with supervisor.*
4. *Fieldwork/visits by research staff. Researcher to complete with Research Centre Head.*

FIELDWORK DETAILS

Name Lisa Marzano

Student No
Research Centre (staff only).....

Supervisors Dr. Joanna Adler and Dr. Karen Ciclitira

Degree course MPhil/PhD Psychology

'ephone numbers and name of next of who may be contacted in the event of accident

NEXT OF KIN

Name Patrick Hanna

Phone [redacted]1

ysical or psychological limitations to rying out the proposed fieldwork

None

.....

health problems (full details) ch may be relevant to proposed work activity in case of emergencies.

None

.....

lity (Country and Region)

[redacted].

.....

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Arrangements

Public transport

.....

mprebensive travel and health ce must always be obtained for dent overseas fieldwork.

.....

f Travel and Fieldwork

October 2005

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.....

E READ THE INFORMATION OVERLEAF VERY CAREFULLY

Identification and Risk Assessment **PLEASE READ VERY CAREFULLY**

calities to be visited or specify routes to be followed (Col. 1). Give the approximate date

enter 'NOT VISITED' (Col 2). For each locality, enter the potential hazards that may be identified beyond those accepted in everyday life. Add details giving cause for concern (Col. 3).

Examples of Potential Hazards :

Adverse weather: exposure (heat, sunburn, lightening, wind, hypothermia)
Terrain: rugged, unstable, fall, slip, trip, debris, and remoteness. Traffic: pollution.
Demolition/building sites, assault, getting lost, animals, disease.
Working on/near water: drowning, swept away, disease (weils disease, hepatitis, malaria, etc), parasites', flooding, tides and range.
Lone working: difficult to summon help, alone or in isolation, lone interviews.
Dealing with the public: personal attack, causing offence/intrusion, misinterpreted, political, ethnic, cultural, socio-economic differences/problems. Known or suspected criminal offenders.
Safety Standards (other work organisations, transport, hotels, etc), working at night, areas of high crime.
Ill health: personal considerations or vulnerabilities, pre-determined medical conditions (asthma, allergies, fitting) general fitness, disabilities, persons suited to task.
Articles and equipment: inappropriate type and/or use, failure of equipment, insufficient training for use and repair, injury.
Substances (chemicals, plants, bio- hazards, waste): ill health - poisoning, infection, irritation, burns, cuts, eye-damage.
Manual handling: lifting, carrying, moving large or heavy items, physical unsuitability for task
f no hazard can be identified beyond those of everyday life, enter 'NONE'.

ive brief details of fieldwork activity:

esearcher intends to conduct semi-structured, face-to-face interviews with 15 to 20 adult male prisoners, who repeatedly injure lves, with no apparent suicidal intent. The interviews will focus on participants' experiences of imprisonment, their relationships on officers, and their self-harming behaviour.

.. LOCALITY/ROUTE	2. LAST VISIT	3. POTENTIAL HAZARDS
[redacted]h	August 2005	Lone interviews (e.g. difficult to summon help) Dealing with the public: risk of unwillingly causing offence/intrusion or being misinterpreted; potential political, ethnic, cultural, socio-economic differences/ problems. Dealing with known or suspected offenders.

versity Fieldwork code of Practice booklet provides practical advice that should be followed in ; and conducting fieldwork.

imisation/Control Measures **PLEASE READ VERY CAREFULLY**

zard identified (Col 3), list the precautions/control measures in place or that will be taken (Col 4) to

acceptable levels", and the safety equipment (Col 6) that will be employed.

Assuming the safety precautions/control methods that will be adopted (Col. 4), categorise the fieldwork risk for each location/route as negligible, low, moderate or high (Col. 5).

Risk increases with both the increasing likelihood of an accident and the increasing severity of the consequences of an accident.

An acceptable level of risk is: a risk which can be safely controlled by person taking part in the activity using the precautions and control measures noted including the necessary instructions, information and training relevant to that risk. The resultant risk should not be significantly higher than that encountered in everyday life.

Examples of control measures/precautions:

Providing adequate training, information & instructions on fieldwork tasks and the safe and correct use of any equipment, substances and personal protective equipment. Inspection and safety check of any equipment prior to use. Assessing individuals fitness and suitability to environment and tasks involved. Appropriate clothing, environmental information consulted and advice followed weather conditions, tide times etc.). Seek advice on harmful plants, animals & substances that may be encountered, including information and instruction on safe procedures for handling hazardous substances. First aid provisions, inoculations, individual medical requirements, logging of location, route and expected return times of lone workers. Establish emergency procedures (means of raising an alarm, back up arrangements). Working with colleagues (pairs). **Lone working is not permitted where the risk of physical or verbal violence is a realistic possibility.** Training in interview techniques and avoiding /defusing conflict, following advice from local organisations, wearing of clothing unlikely to cause offence or unwanted attention. Interviews in neutral locations. Checks on Health and Safety standards & welfare facilities of travel, accommodation and outside organisations. Seek information on social/cultural/political status of fieldwork area.

Examples of Safety Equipment: Hardhats, goggles, gloves, harness, waders, whistles, boots, mobile phone, ear protectors, bright fluorescent clothing (for roadside work), dust mask, etc.

If proposed locality has not been visited previously, give your authority for the risk assessment stated or indicate that your visit will be preceded by a thorough risk assessment.

4. PRECAUTIONS/CONTROL MEASURES	5. RISK ASSESSMENT	6. EQUIPMENT
Safety knowledge and training. Knowledge of and training in HM Prison Service Health and Safety policy and procedures. Keeping staff informed of my location within the prison at all times. Conducting all interviews in designated interview rooms (these have special windows installed in the doors for increased visibility from the landings, and are equipped with alarm/panic buttons). Training in interview techniques. Awareness of cultural, social, political and ethnic differences. Strict compliance with the ethical guidelines set out by Middlesex University and the British Psychological Society.	Low/Moderate	Suitable clothing (i.e. wearing of clothing unlikely to cause offence or unwanted attention) Whistle provided by HM Prison Service (to be worn at all times).

PLEASE READ INFORMATION OVERLEAF AND SIGN AS APPROPRIATE

DECLARATION: The undersigned have assessed the activity and the associated risks and declare that there is no

significant risk or that the risk will be controlled by the method(s) listed above/over. Those participating in the work have read the assessment and will put in place precautions/control measures identified.

NB: Risk should be constantly reassessed during the fieldwork period and additional precautions taken or fieldwork discontinued if the risk is seen to be unacceptable.

Signature of Fieldworker (Student/Staff)	[signature]	**Date**	4/10/05
Signature of Student Supervisor	[signature]	**Date**	4/10/05

APPROVAL: (ONE ONLY)

Signature of Curriculum Leader (undergraduate students only)	[signature]	**Date**	6/10/05
Signature of Research Degree Co-ordinator or Masters Course Leader or Taught Masters Curriculum Leader		**Date**	
Signature of Research Centre Head (for staff fieldworkers)		**Date**	

FIELDWORK CHECK LIST

Ensure that **all members** of the field party possess the following attributes (where relevant) at a level appropriate to the proposed activity and likely field conditions:

- Safety knowledge and training?
- Awareness of cultural, social and political differences?
- Physical and psychological fitness and disease immunity, protection and awareness?
- Personal clothing and safety equipment?
- Suitability of fieldworkers to proposed tasks?

Have all the necessary arrangements been made and information/instruction gained, and have the relevant authorities been consulted or informed with regard to:

- Visa, permits?
- Legal access to sites and/or persons?
- Political or military sensitivity of the proposed topic, its method or location?
- Weather conditions, tide times and ranges?
- Vaccinations and other health precautions?
- Civil unrest and terrorism?
- Arrival times after journeys?
- Safety equipment and protective clothing?
- Financial and insurance implications?
- Crime risk?
- Health insurance arrangements?
- Emergency procedures?
- Transport use?
- Travel and accommodation arrangements?

Important information for retaining evidence of completed risk assessments: Once the risk assessment is completed and approval gained the **supervisor** should retain this form and issue a copy of it to the fieldworker participating on the field course/work. In addition the **approver** must keep a copy of this risk assessment in an

Appendix 3a. RECRUITMENT ADVERT POSTED ON THE PRISON BULLETIN

The Impact of Self-Harm on Prison Officers: Experiences, reactions and support needs

Lisa Marzano, from Middlesex University, is currently conducting a study in consultation with the Safer Custody Group, Prison Service HQ, on the impact of self-harm on prison officers. The main purpose of this research is to explore the views and concerns of officers working with prisoners who repeatedly self-harm, and to identify staff needs and concerns. If you would like to be interviewed as part of this research, please contact Lisa on 0795 ****. The interview would last for about 30 minutes and could be suspended or stopped at any time. If you agree to participate in this research your details will be treated with the strictest confidentiality, and all your answers will remain anonymous.

Appendix 3b(i). CONSENT FORM (OFFICERS)

The Impact of Self-Harm on Prison Staff: Experiences, reactions and support needs

I am currently conducting a study on the psychological impact of self-harm on prison staff. This research is funded by the Economic and Social Research Council (ESRC) and will provide material for my postgraduate degree in psychology.

The main purpose of this research is to explore the views and concerns of prison officers working with prisoners who self-harm, and to identify staff needs and concerns. It would be most helpful if you would agree to be interviewed for this research and discuss your views and experiences about this. If you do agree to participate, the interview will be conducted in private and will be audio-taped. The interview will last for about 45 to 60 minutes and can be suspended or stopped at any time.

Please note that although it would be very helpful if you do participate in this research, your participation is completely voluntary. If you do decide to take part, you have the right to withdraw at any time. Furthermore, if you agree to be interviewed, your details will be treated with the strictest confidentiality, and all your answers will remain anonymous. Some short extracts from your interview may be published in academic articles, but will contain no information or references which could identify you or the prison where you work.

Please do not hesitate to ask any questions about this or the research if anything is unclear.

Thank you

I have read and understood the above and I agree to participate in this study.

Signed: Date:

Appendix 3b(ii). CONSENT FORM (HEALTHCARE STAFF)

The Impact of Self-Harm on Prison Nurses: Experiences, reactions and support needs

I am currently conducting a study on the psychological impact of self-harm on prison nurses. This research is funded by the Economic and Social Research Council (ESRC) and will provide material for my postgraduate degree in psychology.

The main purpose of this research is to explore the views and concerns of nurses working with prisoners who self-harm. It would be most helpful if you would agree to be interviewed for this research and discuss your experiences about this. If you do agree to participate, the interview will be conducted in private and will be audio-taped. The interview will last for about 30 to 45 minutes and can be suspended or stopped at any time.

Please note that although it would be very helpful if you do participate in this research, your participation is completely voluntary. If you do decide to take part, you have the right to withdraw at any time. Furthermore, if you agree to be interviewed, your details will be treated with the strictest confidentiality, and all your answers will remain anonymous. Some short extracts from your interview may be published in academic articles, but will contain no information or references which could identify you or the prison where you work.

Please do not hesitate to ask any questions about this or the research if anything is unclear.

Thank you

I have read and understood the above and I agree to participate in this study.

Signed: Date:

Appendix 3b(iii). CONSENT FORM (SPECIALISTS)

The Impact of Self-Harm on Prison Staff: Experiences, reactions and support needs

I am currently conducting a study on the psychological impact of self-harm on prison staff. This research is funded by the Economic and Social Research Council (ESRC) and will provide material for my postgraduate degree in psychology.

The main purpose of this research is to explore the views and concerns of prison officers working with prisoners who self-harm, and to identify staff needs and concerns. It would be most helpful if you would agree to be interviewed for this research and discuss your views about this issue, as well as provide some information about the suicide and self-harm policy and procedures within your establishment. If you do agree to participate, the interview will be conducted in private and will be audio-taped. The interview will last for about 45 to 60 minutes and can be suspended or stopped at any time.

Please note that although it would be very helpful if you do participate in this research, your participation is completely voluntary. If you do decide to take part, you have the right to withdraw at any time. Furthermore, if you agree to be interviewed, your details will be treated with the strictest confidentiality, and all your answers will remain anonymous. Some short extracts from your interview may be published in academic articles, but will contain no information or references which could identify you or the prison where you work.

Please do not hesitate to ask any questions about this or the research if anything is unclear.

Thank you

I have read and understood the above and I agree to participate in this study.

Signed: Date:

Appendix 3c. OFFICERS' SEMI-STRUCTURED INTERVIEW SCHEDULE

1. Gender of Officer

2. Age – Ethnicity - Grade - Wing Classification/Type

3. Role on wing

4. How long have you been a Prison Officer?

5. How long have you worked in this prison/on this wing?

6. Have you worked in other prisons/on other wings before? If so, where? *(How did this/these differ from the one where you currently work in terms of prisoner population, size, classification, etc.)*

7. What is the morale like amongst the officers at this establishment?

8. How would you describe officer-prisoner relationships in this establishment?

I would like to ask you a few questions about your work with prisoners who self-harm...

9. How would you define self-harm? (*Would you distinguish between different types of self-harm (e.g. deliberate self-harm and attempted suicide)? On what basis would you make such distinction(s)? What do you think the main differences/similarities are? How would you assess intent? If they discuss issues around 'seriousness' ask 'what do you consider to be 'serious' self-harm?'. Ask for examples, etc.)*

For the purposes of this interview, I would like to concentrate on 'repetitive' self-injury, by which I mean chronic self-inflicted harm carried out with no apparent suicidal intent (irrespective of the circumstances, method and/or severity of the injury or injuries).

10. What is your experience of working with prisoners who repetitively self-injure? (*How long have you worked with prisoners who self-harm repetitively? How many prisoners who self-harm repetitively have you worked with? Are you currently working with prisoners who self-harm repetitively? Have you ever been deployed in specifically tackling self-harming behaviour?*)

11. How much time during your average working day do you spend taking care of prisoners who repetitively self-injure?

12. What are the signs that you use to tell that someone is 'at risk'?

13. What do you do if a prisoner is identified as being 'at risk' of self-harm (with no suicidal intent)? (*How do you respond?*)

14. Have you heard of the new 'Assessment, Care in Custody and Teamwork' (ACCT) approach? If so, what do you think of it? Despite what I said above, I think I should keep this question because it ties in with issues around staff-prisoner relationships etc.

15. What do you think of the role Prison Officers have in managing and preventing (non-suicidal, repetitive) self-harm?

16. How successfully are they supported in that role?

17. What role do you think Prison Officers *should* have in managing and preventing (non-suicidal, repetitive) self-harm?

18. Is there any aspect of your work which you feel may affect the way in which you deal with and manage prisoners who repeatedly self-harm?

Now I would like to ask you a few questions about what you think causes prisoners to repeatedly self-harm with no apparent suicidal intent.

19. Why do you think prisoners self-harm? Do you think there are any underlying causes? (*Long and short-term causes + triggers*)

20. What function(s) do you think repetitive self-harm serves for people who engage in this form of behaviour? (*What, if anything, do you think they are trying to obtain by self-harming repeatedly? How do you think it makes them feel? What do you think it means to them?)*

21. What do you do if a prisoner self-harms (with no suicidal intent)? (*How do you respond?*)

22. Do you feel able to deal with prisoners who repeatedly self-harm? *(What sort of skills do you feel you need in order to work with prisoners who self-harm repeatedly? Do you feel you have these skills? Etc.)*

23. What do you feel about prisoners who repeatedly self-harm with no apparent suicidal intent? (*What do you think of them? What does their behaviour make you feel? How do you feel about self-harm?)*

24. Do you have any outlet for these feelings? *(How do you/staff deal with these feelings?)*

25. Have you dealt with an incident of repetitive self-injury in the last six months? Please think back to the last time you dealt with a repetitive self harm incident, then: how did it make you feel? What did you do about it for the prisoner? What did you do about it for yourself? What kind of response did you get from senior management, etc.?

26. What is the most challenging aspect of working with prisoners who repeatedly self-harm? *(What are your main problems or difficulties in working with prisoners who repeatedly self-harm?)*

27. What is the most satisfying aspect of working with prisoners who repeatedly self-harm? *(Does anything positive ever come out of your work with people who repeatedly self harm?)*

28. Does this area of your work affect the rest of your work? (*Do these feelings ever get in the way of your work? Do they affect the way in which you deal with and manage prisoners who repeatedly self-harm?*)

Does it affect your relationships/the way you interact with prisoners who repeatedly self-harm?

29. Does it affect your life outside of work (i.e. affect you on a personal level? If so, in what way?)

30. Are there any aspects of your life in general which you feel may affect the way in which you deal with and manage prisoners who self-harm?

31. Do you ever discuss these issues with anyone? (*If so, with whom? How often? Etc. If not, why not?)*

32. Do you feel supported by your colleagues and senior officers in your work with prisoners who repeatedly self-harm?

33. What sources of support exist for staff who work with prisoners who repeatedly self-harm? What do you think of those services/staff?

34. Have you ever received any official support related to your work with prisoners who self-harm? (*If so, what kind of support did you receive? Did you find it helpful? Etc.. If not, why have you never received/sought support? Have you/would you ever considered it?*)

Do staff, in general, use these services?

35. What support would you like to receive? What sort of initiatives and approaches do you think would be helpful/unhelpful? What do you think would work in the prison context?

36. Do you think there should be specific interventions to support staff in this particular area of work?

37. If, in order to facilitate training and role conflict etc. / to help people with this challenging area of work, there had to be some form of regular debriefing or ongoing support, what would you think about that? What form do you think it should take?

38. Have you ever received any specific training in dealing with self-harm? If so, what kind of training did you receive? Did you find it helpful? If not, why not?

39. Is there any training you would like to receive in this area? Do you think any training or preparation could be provided which could help you in this area of work? If so, what?

40. Have you received any mental health training?

41. Have you ever worked with a prisoner who attempted/committed suicide? *(Ask more about this...)*

42. Is there anything you wish to add?

43. Do you have any questions?

Thank you very much for taking the time to participate in this research.

Appendix 3d. HEALTHCARE STAFF'S SEMI-STRUCTURED INTERVIEW SCHEDULE

1. Gender - Age – Ethnicity - Grade – Location

2. Role in the prison *(E.g. primary care, mental health, dual diagnosis, in-reach team, detoxification, etc.)*

3. How long have you been a nurse?

4. How long have you worked in this prison?

5. Have you worked in other locations within this prison/other prisons before? If so, where? *(How did this/these differ from the one where you currently work in terms of prisoner population, size, classification, etc.)*

6. Have you worked in other settings before? *(E.g. hospital, secure unit, etc. If so, how was this different from the work you do now?)*

7. What is the morale like amongst the nurses at this establishment?

8. How would you describe nurses' relationships with prisoners in this establishment?

I would like to ask you a few questions about your work with prisoners who self-harm...

9. I'm interested in how people think and talk about self-harm. The term itself can mean different things to different people, so I think it's quite useful (to avoid confusion) to ask those who I interview, what *they* understand by the term self-harm. How would you define self-harm? *(Do you think there are different types of self-harm (e.g. deliberate self-harm and attempted suicide)? On what basis would you make such distinction(s)? What do you think the main differences/similarities are? How would you assess intent? If they discuss issues around 'seriousness' ask 'what do you consider to be 'serious' self-harm?'. Ask for examples, etc.)*

For the purposes of this interview, I would like to concentrate on 'repetitive' self-injury, by which I mean chronic self-inflicted harm carried out with no apparent suicidal intent (irrespective of the circumstances, method and/or severity of the injury or injuries).

10. What is your experience of working with prisoners who repetitively self-injure? (*How long have you worked with prisoners who self-harm repetitively? How many prisoners who self-harm repetitively have you worked with? Are you currently working with prisoners who self-harm repetitively? Have you ever been deployed in specifically tackling self-harming behaviour?*

11. How much time during your average working day do you spend taking care of prisoners who repetitively self-injure?

12. What are the signs that you use to tell that someone is 'at risk'?

13. What do you do if a prisoner is identified as being 'at risk' of self-harm (with no suicidal intent)? (*How do you respond?*)

14. What is the role of nurses in relation to prisoners who repeatedly self-injure?

15. How successfully are they supported in that role?

16. What role do you think nurses *should* have with prisoners who repeatedly self-injure?

17. Is there any aspect of your work which you feel may affect the way in which you deal with and manage prisoners who repeatedly self-harm?

18. Have you heard of the new 'Assessment, Care in Custody and Teamwork' (ACCT) approach? If so, what do you think of it?

Now I would like to ask you a few questions about what you think causes prisoners to repeatedly self-harm with no apparent suicidal intent.

19. Why do you think prisoners self-harm? Do you think there are any underlying causes? (*Long and short-term causes + triggers*)

20. What function(s) do you think repetitive self-harm serves for people who engage in this form of behaviour? (*What, if anything, do you think they are trying to obtain by self-harming repeatedly? How do you think it makes them feel? What do you think it means to them?)*

21. What do you do if a prisoner self-harms (with no suicidal intent)? (*How do you respond?*)

22. Do you feel able to deal with prisoners who repeatedly self-harm? *(What sort of skills do you feel you need in order to work with prisoners who self-harm repeatedly? Do you feel you have these skills? Etc.)*

23. What do you think about prisoners who repeatedly self-harm with no apparent suicidal intent? (*How do you feel about them? How does their behaviour make you feel? How do you feel about self-harm?)*

24. Do you have any outlet for these feelings? *(How do you deal with these feelings?)*

25. Have you dealt with an incident of repetitive self-injury in the last six months? Please think back to the last time you dealt with a repetitive self harm incident, then:

how did it make you feel? What did you do about it for the prisoner? What did you do about it for yourself? What kind of response did you get from senior management, etc.?

26. What is the most challenging aspect of working with prisoners who repeatedly self-harm? *(What are your main problems or difficulties in working with prisoners who repeatedly self-harm?)*

27. What is the most satisfying aspect of working with prisoners who repeatedly self-harm? *(Does anything positive ever come out of your work with people who repeatedly self harm?)*

28. Does this area of your work affect the rest of your work? (*Do these feelings ever get in the way of your work? Do they affect the way in which you deal with and manage prisoners who repeatedly self-harm? Does it affect your relationships/the way you interact with prisoners who repeatedly self-harm?)*

29. Does it affect your life outside of work (i.e. affect you on a personal level? If so, in what way?)

30. Are there any aspects of your life in general which you feel may affect the way in which you deal with and manage prisoners who self-harm?

31. Do you ever discuss these issues with anyone? (*If so, with whom? How often? Etc. If not, why not? If not mentioned, ask about clinical supervision. How often do you have clinical supervision? Do you find it useful? Do you ever discuss these issues as part of your clinical supervision? Etc.)*

32. Do you feel supported by your colleagues and senior management in your work with prisoners who repeatedly self-harm?

33. What sources of (practical and emotional) support exist for nurses who work with prisoners who repeatedly self-harm? *(What do you think of those services/staff? Do staff, in general (i.e. uniformed and non-uniformed), use these services?)*

34. Have you ever received any official support related to your work with prisoners who self-harm? (*If so, what kind of support did you receive? Did you find it helpful? Etc.. If not, why have you never received/sought support? Have you/would you ever considered it?*)

35. What support would you like to receive? What sort of initiatives and approaches do you think would be helpful/unhelpful? What do you think would work in the prison context?

36. Do you think there should be specific interventions to support staff in this particular area of work? *(By 'staff', I mean nurses and officers, as well as civilian staff)*

37. If, in order to facilitate training/help people with this challenging area of work, there was some form of regular debriefing or ongoing support, what would you think about that? What form do you think it should take?

38. Are there other areas of work for which you would like to receive support?

39. Have you ever received any specific training in dealing with self-harm? *(If so, what kind of training did you receive? Did you find it helpful? If not, why not? If not mentioned, asked if they have received ACCT training, and mental health training)*

40. Is there any training you would like to receive in this area? *(Do you think any training or preparation could be provided which could help you in this area of work? If so, what?)*

41. Have you ever worked with a prisoner who attempted/committed suicide? *(Prompt reactions, support received/wanted, etc.)*

42. Is there anything you wish to add?

43. Do you have any questions?

Thank you very much for taking the time to participate in this research.

Appendix 3e. SPECIALISTS' SEMI-STRUCTURED INTERVIEW SCHEDULE[1]

Personal details:

1. Age:
2. Gender:
3. Ethnicity:
4. Years of service in this establishment:
5. Have you worked as a Specialist (insert role as appropriate) in other prisons? YES/NO

→ If so, where?

About your establishment ...

6. Staff-prisoner ratio: _____
7. Number of self-inflicted deaths in the establishment in the last twelve months
8. Does this represent an increase/decrease over previous years?
9. How would you explain this increase/decrease?
10. Number of self-harm incidents occurred in the establishment within the last twelve months
11. Does this represent an increase/decrease over previous years?
12. How would you explain this increase/decrease?
13. Number of prisoners currently on an open ACCT form (or F213SH if applicable)

Self-harm

14. What do you understand by the term self-harm?

For the purposes of this interview, I would like to concentrate on 'repetitive' self-injury, by which I mean chronic self-inflicted harm carried out with no apparent suicidal intent (irrespective of the circumstances, method and/or severity of the injury or injuries).

15. Approximately how many incidents of repetitive 'non-suicidal' self-harm occur in this establishment each month?
16. Approximately how many prisoners are involved in these incidents?

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[1] Different adaptations of this interview schedule were used when interviewing other specialist staff. As the fieldwork progressed, these also begun to include questions regarding the impact of self-harm on healthcare staff, and on specialists themselves. Questions 6 to 13 were only asked to the Governing Governor, Safer Custody Governor and Suicide Prevention Co-ordinator.

17. What factors do you think contribute to prisoners' repeatedly self-harming?

18. What function(s) do you think repetitive self-harm serves for people who engage in this form of behaviour?

19. What do you feel about prisoners who repeatedly self-harm?

20. Have you ever received any specific training in dealing with or managing self-harm?

Self-harm policy

21. Are there any special interventions in your establishment to support prisoners who self-harm with no apparent suicidal intent? If so, please provide details

22. Is there a listener/peer support scheme in this establishment? YES/NO

23. Please provide details of Suicide Prevention Team: membership, leadership, meeting schedule and functions (*E.g. How often does the team meet? Who regularly attends meetings? Etc.*)

24. What do you think of the current policy (both in terms of *prevention* and *management*)?

25. What improvements would you make?

26. Have you heard of the new ACCT approach? If so, what do you think of it?

27. Do you think there should be separate policies and procedures for suicide and self-injury (or for different types of self-harm)?

28. Have you, or someone in your establishment, introduced any innovations in this area in terms of policy and/or practice?

29. What is your role in the prevention of repetitive, non-suicidal self-harm?

30. What is your role in the management of prisoners who repeatedly self-harm with no apparent suicidal intent?

I would like you to now consider the roles that Prison Officers play in your suicide and self-harm strategy.

31. How are prison officers made aware of the policy?

32. What role and responsibilities do Prison Officers have in managing non-suicidal self-harm?

33. What role and responsibilities do Prison Officers have in preventing non-suicidal self-harm?

34. How many Prison Officers from this establishment have received specific training in dealing with self-harm in the last year?

35. What type of training did they receive?

36. Who is responsible for the delivery of local training in dealing with self-harm?

37. How do you think staff feel about prisoners who repeatedly self-harm? *(How do they respond to them? How well do you think they understand prisoners who self-harm and their behaviour, needs, feelings and motivations?)*

38. Would you say that staff generally get on well in this establishment? (*Would you say they generally pull together? Is there some kind of 'canteen culture' in this establishment? Etc.)*

39. How would you describe staff-prisoner relationships?

40. What do you think are the main problems or difficulties of staff in working with prisoners who repeatedly self-harm?

41. How do staff deal with working with prisoners who repeatedly self-harm?

42. What, if any, impact do you think prisoners' self-harming behaviours have upon staff's personal lives?

43. What, if any, impact do you think prisoners' self-harming behaviours have upon staff's work?

Staff support

44. What sources of support exist for staff who work with prisoners who self-harm?

45. What do you think of those services/staff?

46. Do staff use these services?

47. Please provide details of Local Care team: membership, meeting schedule and terms of reference

48. What sort of initiatives and approaches do you think would be helpful/unhelpful to support staff working with prisoners who repeatedly self-harm? What do you think would work in the prison context?

49. Are you aware of any 'good' practices or schemes operating in this or other establishments to support staff working with prisoners who repeatedly self-injure?

50. Is there anything you wish to add to anything you have said thus far?

51. Do you have any questions?

Thank you very much for taking the time to participate in this research.

Appendix 3f. DEBRIEFING LETTER

Thank you for agreeing to participate in this research

I would like to stress once again that the interview will be completely confidential. All the participants' details and any identifying factors will be changed in order that all participants' answers remain anonymous.

If you have any questions about this research, please do not hesitate to contact me by e-mail at L.Marzano@mdx.ac.uk or by telephone on 0208 411 6861.

Please find enclosed a list of useful contacts and organisations that offer advice and support to professionals working with people who self-harm.

With best wishes,

Lisa Marzano

Useful contacts and organisations

Local Care Team (PICT) [Information withheld to protect participant anonymity]

Staff Care and Welfare Services: Tel. 0845 6072034.

Safer Custody Group
Abell House, John Islip Street, London SW1 4LH.

National Self-Harm Network
Tel: 020 7916 5472
Information, training and campaigning for better understanding of people who self-harm.
PO Box 16190
London NW1 3WW

Samaritans
Tel: 08457 909090
National help-line
Website: http://www.samaritans.org.uk/
Email: a.canese@samaritans.org

Artree Training Consultancy
Tel: 0117 954 0426
Members of the organisation travel to prisons all over England to train prison officers and offenders about self-harm and art therapy.
C/o 28 Horley Road, St Werburghs. Bristol, BS2 9TJ
Email: enquiries@artree.co.uk

The Basement Project
Tel: 01873 856524
The Basement project provides support groups and literature for individuals as well as an educational programme for workers (including training, supervision, and consultation).
PO Box 5, Abergavenny, NP7 5XW
Website: http://freespace.virgin.net/basement.project/
Email: basement.project@virgin.net

Bristol Crisis Service for Women
Tel: 0117 925 1119
National help-line for women in distress; publications and training on self-injury.
PO Box 654
Bristol BS99 1XH
Website: http://www.users.zetnet.co.uk/BCSW/

MIND
Tel: 020 8519 2122
Provide information leaflets on self-harm and personality disorder.
15-19 Broadway, London, E15 4BQ
Website: http://www.mind.org.uk/

Reaside Clinic
Tel: 0121 453 6161
This group exists primarily to provide information to practitioners who work with people who self injure. They can offer education literature, a resource pack, seminars and support networks.
Contact: Sarah Beasley
Avon Unit, Reaside Clinic, Birmingham Great Park, Rubery, Birmingham. B45 9BE

Useful Publications

Arnold, L. (2001) Working with People Who Self-Injure: Modular Training Pack. Bristol, Bristol Crisis Service for Women.

Babiker, G. and Arnold, L. (1997) The language of Injury. Leicester: British Psychological Society.

Bird, L. and Faulkner, A. (2001) Suicide and Self-Harm. London: The Mental Health Foundation.

Favazza, A.R. (1996) Bodies Under siege: Self-mutilation and Body modification in Culture and Psychiatry (2nd ed.). London: The Johns Hopkins University Press.

HM Prison Service (2001) Prevention of Suicide and Self-Harm in the Prison Service: An Internal Review. London: Prison Service.

Spandler, H. (1996) Who's Hurting Who? Young People, Self-harm and Suicide. Manchester: 42nd Street.

Strong, M. (2000) A Bright Red Scream: Self-Mutilation and the Language of Pain. London: Virago.

The Howard League for Penal Reform (1999) Scratching the Surface: The Hidden Problem of Self-Harm in Prisons, London, Howard League.

The National Self-Harm Network (1998) The Hurt Yourself Less Workbook. London: MIND.

Towl, G., Snow, L. and McHugh M., (Eds) (2000) Suicide in Prisons. Leicester: BPS.

Appendix 4. Research Materials Prisoners' Study

Appendix 4a. INFORMATION SHEET

I am a research student at Middlesex University, and I would like to invite you to take part in a study on self-harming behaviour amongst adult male prisoners. This research is funded by the Economic and Social Research Council (ESRC) and will provide material for my postgraduate degree in psychology.

The main purpose of this study is to explore the views, motivations and concerns of prisoners who repeatedly self-harm. I would be very grateful if you would agree to be interviewed for this research and discuss your experiences about this. The interview will also include questions about how you get on with your family, and with people within the prison.

If you do agree to take part:

- Your participation is completely voluntary.
- The interview will be conducted in private and will be audio-taped.
- The interview will last for about 45 to 60 minutes.
- You have the right to withdraw at any time.
- Although the researcher cannot guarantee total confidentiality, all your answers will remain anonymous and confidential, within the limits imposed by the law. If you disclose the intention to commit a crime or cause serious harm to yourself or others, I will have to inform a member of staff.
- Some short extracts from your interview may be published in academic articles, but will contain no information or references which could identify you.

Please do not hesitate to ask any questions if anything about this information, or the research in general, is unclear.

Thank you

Lisa Marzano

Appendix 4b. CONSENT FORM

Please do not sign this consent form until you have read the information leaflet and you have been given satisfactory answers to any questions that you may have about this research. Please answer the following questions before signing this form:

Have you read the information sheet about this study?	YES/NO
Have you had an opportunity to ask questions about this study?	YES/NO
Have you received satisfactory answers to all your questions?	YES/NO
Have you received enough information about this study?	YES/NO
Do you agree to take part in this study?	YES/NO

Signed..... Date.....

Printed name.....

Appendix 4C. PRISONERS' INTERVIEW SCHEDULE

First of all, I would like to ask you a few questions about your experience of imprisonment and how you get on with other people in here:

1. As someone from the outside, I'm interested to hear about your life in here. Although this may sound a bit basic, would you please tell me what it's like for you being in prison, on this sentence?
2. How well would you say that you get on with other people in here?
3. Are there any people in here you can talk to when you are feeling distressed? (If so, who? Etc.. If not, why not? Etc.)
4. What do you think of the prison officers on the wings?
5. If applicable: What would improve your relationship with officers on the wing?

Next, I would like to ask you a few questions about your relationship with friends and family outside:

6. Will you please tell me a bit about your family when you were growing up? (If brought up in an institution ask them about their experiences, about the care-givers, friends etc.)
7. How do you get on with your family now? (Or, are you still in touch with any of the people who ran the home, etc., if so, how well would you say that you get on with them?)
8. Is there anyone within your family, or anyone else on the outside that you can talk to when you are feeling distressed? (If so, what is their connection to you? Etc.? If not, why not?)

Now, a few, more general, questions about the ways in which you deal with difficult feelings and situations...

9. Have you ever been able to talk about your problems and feelings? (What do you think in relation to talking about difficult feelings and situations? In general, do you find it easy to talk to people about your problems and feelings?)

10. Is there any event, emotion or feeling that you find particularly difficult talking about? (If so, what? Why is it hard to talk about them?)

11. Is there any other way in which you personally like to express your emotions and feelings? (E.g. keeping a diary, painting, poetry, etc.)

12. In general, has the way in which you deal with difficult feelings and situations changed since you have been in prison? If so, how has it changed?

Now, about your self-harming behaviour...

13. I'm interested in how people think and talk about self-harm. The term itself can mean different things to different people, so I think it's quite useful (to avoid confusion) to ask those who I interview, what *they* understand by the term self-harm. How would you define self-harm? (Do you think there are different types of self-harm (e.g. deliberate self-harm and attempted suicide)? On what basis would you make such distinction(s)? What do you think the main differences/similarities are? Do you think self-harming is different from trying to commit suicide? Etc.)

14. When was the first time you self-harmed? (What happened? What made you self-harm? Were you in prison at the time?)

15. Have you ever self-harmed outside prison?

16. How often do you self-harm?

17. Why do you self-harm? (If not discussed, ask about suicidal intentions - Is it a means of ending your life?)

18. Is there anything in particular that triggers/precipitates your self-harm?

19. What method(s) do you use to harm yourself? (E.g. burn/cut/strangulation etc.. Why have you chosen this/these method(s) rather than others?)

20. How do you feel after you self-harm?

21. Is your self-harming helpful in any way? (E.g. Does it make you feel better? Does anything good ever come out of your self-harming?)

22. How do you think prison officers feel about your self-harming? (Do you feel they understand why you self-harm? Do you think they feel able to deal with your self-harming? Etc.)

23. How do officer respond to your self-harming?

24. How would you like them to respond? (What is a helpful/unhelpful response?)

25. In what ways do these reactions affect you?

26. How do you think your self-harm affects them (if at all)?

27. How do the nurses and doctors respond to your self-harming?

28. Do you talk to anyone about your self-harming? (If so, who? Etc. If not, why not? Etc.)

29. Do you wish you could stop self-harming?

30. What could be done to help you stop, or at least reduce your self-harming?

31. Is there anything special in this prison that is to support you, with regards to your self-harming? (e.g. Listeners, Samaritans, one-to-one and group counselling, etc.. Do you use them? What do you think of them? Etc.)

32. What do you think of the ACCT process? (How do you feel about being on an ACCT? Is it helping you? Do you feel supported? What's good and bad about it? What improvements would you make? If applicable – is it different from the old system?)

33. How would you feel about being housed on a special wing for prisoners who self-harm?

34. Is there any other kind of support you would like to receive?

35. Have you ever tried to kill yourself? (If so, could you tell me a bit more about this? Were you in prison/outside/both/other? How many times? When was the last time? Etc.)

36. If not discussed, ask if currently withdrawing from drugs and/or alcohol.

37. Is there anything you would like to ask me, or add to what you have said so far?

Appendix 4d. DE-BRIEFING LETTER

Thank you for agreeing to participate in this research

Please find enclosed a list of useful services, contacts and organisations that offer advice and support to people who self-harm. If you are feeling distressed after this interview, please speak to a member of staff or contact one of the services listed overleaf.

With best wishes

Useful services at HMP [Information withheld to protect participant anonymity]

HMP [Information withheld to protect participant anonymity] offers a range of services and programmes (see list below). If you feel that any of these might be relevant to you, and would like to receive more information, please speak to a member of staff or contact SO [Information withheld to protect participant anonymity], Suicide Prevention Co-ordinator.

- Listeners
- Samaritans
- Crisis Counselling
- Self-harm support group
- Adjusting to prison life group
- Living skills group
- Yoga
- Acupuncture
- Art
- Family Man course (parenting skills)
- Fathers Inside
- Sycamore (group looking at victim empathy)
- Enhanced thinking skills
- Sex offender treatment programme
- Chaplancy
- General counselling
- Mental health counselling
- Drugs counselling

Useful contacts and organisations

Samaritans
Tel: 0207 734 2800
National help-line
Email: a.canese@samaritans.org

The Basement Project
Tel: 01873 856524
The Basement project provides support groups and literature for individuals as well as an educational programme for workers (including training, supervision, and consultation).
PO Box 5, Abergavenny, NP7 5XW

MIND
Tel: 020 8519 2122
Provide information leaflets on self-harm.
15-19 Broadway, London, E15 4BQ

National Self-Harm Network
Tel: 020 7916 5472
Information, training and campaigning for better understanding of people who self-harm.
PO Box 16190
London NW1 3WW

Newsletter

SASH - Survivors of Abuse and Self-Harming
Pen friend network offers support, friendship and understanding in writing.
SASH, 20 Lackmore Road
Enfield, Middlesex. EN1 4PB

Appendix 4e. POST-INTERVIEW CONSENT

Thank you for taking part in this research.

In order to gain a fuller picture of your background and experiences, it would be very useful for me to find out a bit more about you and your previous convictions. The easiest way is if I can access your file but I will not do this without your consent. Should you prefer to answer the questions now, then we can go through them here, instead. Either way, should you agree to this, your details will remain private, and will be treated with the strictest confidentiality.

I have read and understood the above and I agree to the researcher having access to my personal files.

Signature: Printed Name:

Date:

Personal Information

Age

Ethnicity

Marital status Single/married/cohabiting/separated or divorced/widowed

Children YES/NO (If YES, how many? How old are they?)

Penal History

Status Remand/ Convicted/ Sentenced/ Civil/ Detained

Offence Type

In total, how long have you been in custody on this offence (including both before and after your sentence)?: ____years _____months _____days

If sentenced, length of sentence: _____years _____months

Time left before expected date of release: ____years _____months _____days

Have you been in custody before: YES/NO

If YES, how many times and where?
When was the last time you were in custody?

During current or previous periods of custody, have you been on any programmes or interventions? (If so, please specify)

Appendix 5: Transcription Notation

The interviewer is indicated by the letter L and the participant is indicated by the first letter of his/her pseudonym. When the participant's pseudonym starts with the letter L, the interviewer is indicated by the letters LM.

The following forms of notation as used for the transcription of interviews were adapted from Gail Jefferson's version in Potter and Wetherell (1994, p. 88).

Brackets indicate an overlap by the other speaker between utterances e.g.:
I: What do you k (of self-harm) about self-harm?=

An 'equals' sign at the end of a speaker's utterance indicates the absence of a discernible gap between speakers e.g.:
I: Did you=
A: Yes

Pauses are indicated by number of seconds in brackets, e.g. a 2-second pause: (2)
(.) Indicates a brief (less than one second, but perceptible) pause

Words which are underlined were spoken with emphasis. Words in uppercase were uttered noticeably louder than the surrounding words e.g.:
A: I REALLY, REALLY don't like it. It makes me so unhappy.

A sigh or a loud intake of breath are indicated in the text by ..hh.

A colon indicates an extension of the preceding vowel sound, or phoneme, e.g.:
A: Yeah:h, I see:

Words which could not be heard/understood during transcription are indicated by a lower case x per word e.g.: xx. When whole sentences could not be heard/understood, the term 'inaudible' is used, in square brackets e.g. [inaudible]. When the person transcribing is not sure as to whether a given word or sentence was heard accurately, this

is reported in brackets, followed by two questions marks e.g. (self-harm??)

An uppercase X indicates a name of a person or place which cannot be given for the sake of confidentiality. A description of the relationship of the person, or the type of place (e.g. country) is indicated in curly brackets e.g.: X {cell mate}

Feelings such as anger, or a distinct tone of voice, are described in curly brackets, e.g. {sounded unhappy}

Appendix 6. Sample Summary of Themes

ANALYSIS PRISONER DATA
(Please note that the number in brackets denote participants)

Initial Notes

CONSTRUCTIONS OF SELF HARM
Rationalising self-harm (not sure; can't remember, but I must have ...)
Not knowing what triggers it; not realising they are doing it (some describe dissociative state and/or 'impulses')

Something silly/stupid
Embarrassing – not the done thing (20)
Screaming vs. crying for help (20)
Many talk of the build up of anger, or anger as a trigger, or being violent ... is anger a more socially acceptable emotion for men?
Head butting/punching walls

Defining self-harm by what it is <u>not</u> (Billig) (see also in relation to staff data)

Self-harm vs. attempted suicide

Is it more re: young v adult, than male v female?
In this (almost) all-male environment the comparison seemed not to be with women, but with other men (and masculinities). The issue is not necessarily whether you are a man- but what <u>type</u> of man you are. Indeed female self-harm and women noticeably absent (only mention I think is Richard talking about grooming products and Kieran talking about 'Lesbian tea' and comments re: women having better attitudes and getting more requests for help), which may seem surprising considering that self-harm is traditionally constructed as a female behaviour (does the literature discuss this aspect – if so how?)

<u>Read again staff's construction before analysing for comparison of main themes</u>
Drugs co-occurring with self-harm (because common cause), rather than (or as well as) drugs being a cause of self-harm. (Note: parallel not just with illegal drugs but also with Valium – Andrew)

Like officers, talked of different types of self-harm - but not mutually exclusive

Whereas for staff attention often = medication; for prisoners attention = help (Quentin) being listened to (Richard)

Do staff talk about emotions in relation to self-harm? A lot of prisoners seemed to say they self-harm "through their emotions" (see 4), especially anger

Interesting that frustration is often mentioned as a cause for self-harm by prisoners, and, as the main reaction to self-harm by staff (transference?). Also some parallels re: helplessness, lack of power and control

BACKGROUND

DIAGNOSES AND REACTIONS TO THEM
ADHD, Personality Disorders
How many spoke of their mental health?

CONCERN FOR BODY/HEALTH/GROOMING PRACTICES

STAFF REACTIONS
Staff not knowing or understanding, or wanting to know

Challenge principle of equivalence of treatment – e.g. Richard and Jack
Being bullied by staff (e.g. 11; 10)

Failing 3 elements of 'test of a healthy prison' (resettlement was not discussed)
"The Prisons Inspectorate has four tests of what it calls a 'healthy' prison: that prisoners are held safely, treated with respect for their human dignity, able to engage in purposeful activity, and prepared for resettlement".
Safety re: rape victim with rapists, showers (see Liebling et al., 2005 re: safety and care)
Respect – see quotes re: human rights discourses
Wanting to work; wanting to keep busy

Even when officers are seen as helpful and polite, it doesn't mean that they are perceived to be 'caring' or that prisoners would talk to them ('us and them' split; e.g. Quentin, Bill)

Feeling 'brushed off', 'fluffed about' – staff not having time to talk to them (regardless of whether they want to) – for some this is the/a trigger, for others an actual cause.

Some however said it wasn't the staff's fault –others thought they just take out their family problems on them, bully them, push them to self-harm (see quotes re: taunting, bullying, racism)

Are prisoners more understanding of staff than vice versa? In this context, do officers get more understanding than nurses? Explore racial/racist element (see Isaac) and expectations of 'care'

SUPPORT
Prisoners didn't seem to respond to support/help questions in the same way as officers did.

Despite what staff said, the majority of prisoners seemed not to like being on ACCT. Mainly talked about implications on a pragmatic level (e.g. lack of sleep, not being able to work), but also psychologically (for Nick it was like accepting that he was going 'down that road again'; see also Paul). Staff seemed to have little appreciation of what it meant for prisoners to be on an ACCT plan.

Is the support they want specific to self-harm or for other (e.g. drugs) and more general issues (e.g. respect, safety etc) which may also be triggering their self-harm?

Are people asked often enough if they want to stop? Self-harm almost always automatically assumed to be problematic –but does it 'work' for some people? And, if so, who are we to say they can't do it?

Is it these guys that can't cope with prison, or prison that can't cope with them? (See e.g. Ethan)

COMMENTS ABOUT INTERVIEW SITUATION/INTERVIEWER

Re: reflexivity – being 'just as student', independent (and powerless re: certain things) tends to be described as 'good', as making prisoners open up more, etc. but sometimes it was quite frustrating to feel so powerless (whilst occasionally being a relief - am I also "passing the buck"?)

Some participants so distressed about a particular event/situation/lack of medication, that it was difficult to keep to the interview schedule and/or not to digress

CONSTRUCTIONS SELF-HARM

1. framed as coping/dealing with things 2 5 6 8 12(dealing with emotions/adapting) 14 15(dealing with pressure) 16 18
2. Childish 1(linked with men) 12(implied) 19 (risk taking when young)
3. Having no control over self-harm (1, 4) 13(being pushed to self-harm) 14(fighting the urge to self-harm; being pushed to self-harm); 16, 18 (being impulsive)
4. Being in control of self-harm (4)
5. Re: vulnerable people 1 5 (link with how many defined themselves and/or prisoners in general as victims/survivors/vulnerable)
6. Weird 1
7. Selfish 1
8. Risk taking/game 19 (yet later says it's not a game)
9. Always done 1(link with how many started young + discuss inside v outside)
10. Habitual 2,14 (routine)
11. Private 4 12 15
12. Physical, destructive, violent 5 7 18
13. Sign of weakness 7 8 9 12(+unpredictable)
14. Embarrassing 8 9 11 12 20(can't handle prison)
15. Stupid (makes me look stupid) 9 11 (silly) 17 18 (silly, pathetic and ridiculous) 19
16. Not something prison is geared up for 11, 5
17. Makes you feel like an odd ball: 12/18 (weirdo)
18. Unfair: 18 (on body)
19. Safety valve
20. Like a drug: 1 and 5 (like Valium, calming), 12 (addictive)

Different types, but mine more a) severe and b) re: anxiety (1)
Different types, mine re: release 6 (GQ), 15
Mine severe 7 11 17 18 (not superficial)
Mine serious, not a cry for help 11
Mine physical and destructive 5
Mine real 17, 19 (proper)
Mine not real self-harm 18
2: severity depends on function; don't worry if things go wrong
Mine only scratches 9

Started as child: 1, 2, 4, 5, 6, 7 8 12 15 16 17 18 19(?) 20

Versus (Attempted) suicide
Different but did both 1 2 4 6 12 15 18
Different – not discussed if ever attempted suicide 16
Didn't comments re: difference, but did both 7 8
Not caring either way (distinction irrelevant?) 5; 12 (at the time doesn't worry about it)
Ambivalent (?) 11
Don's want to die in here 11
Not suicidal 17 20

FUNCTIONS

- Attention seeking 1; 7 (when young); 15; 17; 18 (wanting people to listen, before it's too late)
- Cry for help 6 (re: others), 9 (re: detox, but not only – because people don't believe me) 18 (because angry) 20 (screaming for help)
- Wanting people to listen: 18, 19
- Release anxiety, stress, frustration, anger/release/relief 1 2 (70%) 4 5 6 GQ, 8, 12 15, 16, 17 (pressure, anger) 18
- Blackmail/manipulation 1 (sometimes) 3 (30%) 7(only way to manipulate system; medication) 19 (? Getting the job)
- Getting to see the doctor 20
- Fighting the system 11
- Communication 2/4 (*only* means of) 5 (let people know about abuse) 7, 19 (getting my point across)
- Proving things 19
- Keep mind busy 4 12 (take mind off things)
- Get away from myself/forget what's going on: 8 (link with 4?)
- Escape 12 (from situation and then feelings)
- Self-hatred 4 9
- Not hitting someone else 4(staff) 5 7 17 10
- Disrupt staff 4
- Coping 2 5
- Showing people (staff) how much they've upset me 4
- Wanting support (attention?) 5 (not selfish but lonely)
- Doing something about frustration (4)
- Getting that little bit of a buzz 6
- Take aggression out 7 17 (take out anger)

Multiple functions

1 2 4 5 6 7 18

Emotions

1 2 4 5 (especially anger) 6 (yes, but not only) 7(especially anger) 11 17 (confusion, anger, guilt) 19

CAUSES

- Not prison 1 (yet, trigger)
- Not <u>just</u> prison 6
- Being in prison 19
- Abuse (trauma) 1 5 7 12 16 17 19
- What happened in my life 18
- Feeling sad, low 1 6 7 15(depressed) 18 19 20 10 (depression)
- Emotions 4 (anger) 18
- Withdrawing (and not seeing doctor) 9 11 (going to extremes to see doctor)
- Not being out for Christmas 9

- Guilt 9
- Self-hatred 9
- Hearing voices 13; 16 (something or someone tells me to do it)
- Feeling alone 13
- Language problems 13
- Hopelessness 14(suicidal?), 19 (not getting anywhere) 20
- Not finding a way out 17
- Let's see how far I can get 17
- Being ill 18
- Being put down 18
- Don't know 1 6 12 (I ask myself why) 18

(When describing previous episodes 7 talks of attention seeking, alcohol and hormones)

2: there is always a reason
1: not even people who self-harm know why (4 also says that he doesn't always know why he does it; and 12 says he keeps asking himself why)/different reasons and functions, but common backgrounds
7: multiple causes: it's all of these things; 13: multiple triggers; 18; 19: background + being in prison

TRIGGERS

- Feeling unsafe 1 (other prisoners) 19
- Being in prison 9 (officers)
- Officers wind me up 4, 14 18 10
- Getting no help 4
- Being mummy's boy 5
- Nothing else to do 8, 14, 17 (boredom) 19
- Anger: 17 18 (rage) 19 20 10
- No-one to talk to 8 13 18 (no one is listening) 19 (not listening)
- Feeling desperate 12 18
- Thinking/worrying 14 19
- Not coping 16
- Flashbacks 14, 16
- Things/problems going on outside 8, 13 (family problems)
- Rows 15
- Pressure 15, 16
- Build up (merge with above?):14 17
- Multiple
- Don't know 6 8 (dissociative state?) 13 (hallucinating) 15 (it just happens) 18 (in a rage at the time/impulsive)

EFFECTS

- Relaxing 1 (like Valium) 2 (endorphins) 4 (fall asleep) 5 (like drugs) 6 8 (short term) 15 (relief - better than drugs/sight of blood/only relief), 16 (Seeing the blood), 17 (relief)
- Feel better 13, 17 18
- Get what 1 want 2
- Anger 20 (still no help)
- Regret 4 (scars) 8(scars)
- Shame (linked with above) 4 9 12 (I'm a grown man)
- Self-consciousness re: scars/body 5 8
- Pain (after) 17 18 19 20(mental more than psychical)
- Depression 4
- Being put on an ACCT 4
- Not feeling suicidal 5
- Not doing a life sentence 5
- Buzz 6
- Feeling stupid 9
- Effect on others 11

After, questioning why 1 did it (17) and 10

METHODS:

Slashing 1

Multiple:

1; 2 (serious when manipulative; superficial cutting when release); 4 (from scratching to tearing into me) 6 – good quote;

1 and 17 escalation (injuries being deeper)

REACTIONS: GENERAL

Not interested; you are just a piece of paper – need to look at our past 19
I'm not threatening, I'm suffering very badly 20
Think you are attention seeking but I want them to see it how it is 20

OFFICERS

POSITIVE

- They jumped onto it straight away 17
- Improved mentality, attitudes and reactions 5, 6
- They try to help (but...): 1 (you get sod all from them; there is nothing they can do because no cure, no resources, no training) 6 (but managerialism, machismo, shortage of resources and not qualified to deal with mental health issues) 13 (language barrier)
- Sympathetic, but that's not what you need 12

NEGATIVE

- Don't care (with rare exceptions) 8, 12, 13, 14, 16, 17
- Think you are weak and attention seeking 12
- Treat you like a kid 12
- Call me stupid 5 (but understandable) 12
- Laugh and tell me to do it properly 4, 8, 9 (laugh) 12 (laugh)
- Some want you to die 16
- Say 'no pain no game' (not a game to me) 19
- (Threaten to take job and single cell away?) 19
- Don't take it seriously 14
- Never tell me not to do it 4
- Hitting me 4 (cause even more pain than self-inflicted)
- Not searching me properly 4
- Not coming straight away 4
- Not doing anything about it 17
- Think you are a risk to others 13
- Just cut me down and don't talk to me 14
- Just look at you, put you on ACCT 20
- Take me up to see the nurses; not their job 18
- Take me down, bandage me and put me back in cell 20
- Put me on an ACCT and try and talk to me, but I'm not interested 15
- Unsympathetic 7
- Abrupt, but not condemning them 5 (overcrowding etc – they react like this because stressed)
- Don't understand, no awareness of it 12 (and don't want to understand – especially men)
- Don't want to listen 14
- Want to be helpful but don't understand 6 (re: self-harmers not being suicidal)
- Don't understand (think all those who want medication are junkies – however not trained) 10

MIXED (some good some bad + ambivalent)

- First says they don't want him to do it then, after reassurance, that they don't care 16
- They jump onto it and that they are here to help, yet they don't care and can't talk to most of them 17
- A few understand and a few think I'm a pain in the arse because of the paperwork 2
- Some help, some racist, brutal... 3
- Some are ok, but won't help him see a doctor 20
- Most negative, but few exceptions 4
- Some are helpful 9
- Only 3% understand

EFFECTS ON OFFICERS:

- It doesn't affect them because they don't care 17
- Only affects one or two who care – they see it all the time 9
- I don't care how it affects them (I do it for myself) 14
- Annoys them because of paperwork 2; 4 (takes time they don't have), 5
- Freaks them out 1, 6 (panic)
- Trauma 1
- Danger (catching disease) 1
- Annoying and inconvenient 18
- Reaction as a function of deaths 5
- It affects them but won't admit (he understands his point of view) 11
- It pisses them off, but understandable: poor resources, poor training, blackmail 1
- Hassle/causes problems 4 (ACCT) 12 (more work they've got to watch you – that's why negative attitude)

Effect then on prisoners:

- Negative: angry, but can understand (1)
- Annoy me 7
- Reinforces the negativity: 1 (make you feel like scum...)
- If they shout, make me feel worse 5
- Makes you feel like an odd ball 12
- More self-harm because they don't take it seriously 14
- More self-harm because detox issues 12(?)
- Hurt that they are wishing me to hurt myself, but doesn't make self-harm or they will 8
- Made me stop 7
- Doesn't phase me 2; 14 (yet feels like they are punishing him)

NURSES/DOCTORS

POSITIVE

- Clean me up 4
- They like me; more comfortable with them than officers 4
- One doctor tries not to hurt me 5
- Try to help, show sorrow 13
- They care (because they have to) 17
- Nurses ok (but can't do much because system messed up) 10

NEGATIVE

- Doctor who does nothing for no-one 14
- Just patch you up 20
- Just offer you medication
- Not answering cell bell promptly 14
- Problem seeing the doctor 11
- Show you how to cut 8
- They don't care 6, 8, 9 (just another junkie) 12 (shouldn't be called nurses), 14, 19, 20
- Plain horrible 1
- Unsympathetic and negligent 7
- They hate you for it 1 (being persecuted; ridiculous)
- Call you names 1 (selfish), 5, 7 (wasting our time), 20 (stupid)
- Get angry, annoyed, fed up 18, 5, 2(because more work)
- They don't take it seriously – think you are playing with them 14 20
- Judgmental: think they are silly and attention seeking (don't know why you self-harm) 18
- Think you seeking attention (don't see what's inside) 14(good quote) 20
- They patronise you 12
- Don't give you a chance to talk to them 8
- Don't believe you + Very rude 9 (but have to put up with it all the time + people bragging in + racial explanation)
- Tying everyone with the same brush: 9 (re: criminal), 10 (junkie)
- Exchanging information with officers 11
- I refuse treatment, want nothing to do with them + questions competency 15
- Less understanding than officers; wrong way round 1, 12 (but see it all the time-burn out?)
- Worse than officers: 1
- They don't understand 12, 17 (and they are supposed to be trained)
- Don't want to know 19
- No equivalence of care 6 (good quote) 11, 14 (outside they take it seriously), 18 (people in hospital care re: self-harm), 10
- Refuse to give medication 5; x refuse bandaging; 18 (bandage it yourself)

MIXED

- All horrible but 1 doctor
- Nurse bad, doctors good 5

Effect on prisoners:

- Horrible/Make me feel small 1
- Make me feel like an odd ball 12
- Annoying that judgemental 18
- embarrassed to talk re: self-harm (implied) 18
- Sad: they are supposed to be caring 6
- Not asking for help 6
- Make me close up 12
- Doesn't phase me 2, 14,

SPECIALISTS

- Psychologist helped me build myself up/self-harm group 5, 6
- Chaplaincy 5 6 16
- Positive about counsellor 9, 18, 10
- Samaritans 17

- Don't care/can't trust 18
- Negative of counselling 7
- Don't know why excluded from self-harm group 7, 8
- Negative about all psy do-gooders 15

REACTION WANTED

- No preference 2
- None – doesn't want to support from them, nor does he want to stop 15
- People jumping onto it more 17
- More cell searches 17
- Good communication 5 (+ good quote about staff-prisoner relationships)
- Good officer=caring 4 (build my self-esteem)
- Support 8 (=people asking him how he is); 19 (someone I can trust/talk to)
- Treated like adult 12
- For them to understand it's how I adapted to cope 12; 20 (more understanding/training re: mental health issues; at least for some)
- Take it seriously 14 20
- More respect, not being fluffed about 14
- Ambivalent: obviously want sympathy and compassion, but does sympathy make you do it more? Is sympathy realistic given shortage of resources? Is there such thing as a helpful response? 1
- Neither sympathy nor shouting 5
- Sympathy is not enough 11; 19
- On the other hand, interventions are not enough without supportive culture 10

Other help wanted

- Distractions 5 (implied)
- Personal officers (for self-harm) 5
- Suggestion box 5, 6

- More prevention 6
- Cell open more often 5
- Medication 11, 13, 20
- Being able to talk to other prisoners 13
- Work 14
- Officers to be trained 10
- More help with drugs 16, 9

OTHER

System can't cope 5; 6 (can't deal with mental health issues), 11 (re: drugs); 10 (system messed up, not staff's fault)

Things are improving: more proactive support 5, 6 (better training, better mentality)
Support of other prisoners also 5, 13

Do we need ACCT if self-harm? See 6

Macho culture impedes support from male staff 6
Women react better than men 6
Women get asked for help more than men 5

Regardless of self-harm, bad relationship with officers: bullying me 4; 2 and 6 (not bad relationship, but us and them), 7 (brush people off, brutal, racist, uneducated...however lack of staff and training), 8 (always busy, racist –only speak to you when on ACCT), 9 (they've got no feelings – but not all of them), 12 (brutality, not enough respect and common decency), 15 (they are keeping me here), 16 (they are ok as long as you do what they say – you've got no power)

Get on well with officers 17 (for good report)

Mixed: some get on well, some are nasty 18 20

How many said **officers trigger** for self-harm?
4 7 8 (phone call) 9 (listeners episode, phone call) 14 (respect, phone, upset him, wind him up, pushing him to self-harm) 18, 20 (because being pushed off, not getting help), 10 (bullying, not understanding, no respect, sadistic – phone episode)

Self-harm not officers' job 18

I. Is My Work 'Feminist' Enough? Tensions and Dilemmas in Researching Male Prisoners who Self-harm

Lisa MARZANO

> [T]here is a clear link between the pain of imprisonment and harm (as self-inflicted injury or suicide) . . . it is crucial that the reality of this pain and its consequences are reflected in research. (Liebling, 1995: 183)

In focusing my PhD research on the issue of self-harm in prisons, my political agenda was – and remains – to increase awareness of the extent of this 'problem', and of the role of the criminal justice system in 'creating' self-injury. In turn, I hoped that this would stimulate discussion, as well as *action*, in relation to the functions, (over)uses and abuses of imprisonment.

Both theoretically and philosophically, my work was located within the wider literature on the effects of imprisonment (Liebling and Maruna, 2005; Sykes, 1958). A basic premise of this body of research is that, notwithstanding the alleged 'risk' and 'vulnerability' of people in custody (which are in themselves problematic), 'the ethos of an establishment, how inmates are treated, will determine the amount of self-injury' (HM Chief Inspector of Prisons, 1990, quoted in Howard League, 2001: 1). Within this popular framework, self-harm has been conceptualized as a way of coping with the harms and 'pains' of imprisonment, and thus constructed as a test of the 'health', 'moral performance' and 'legitimacy' of our prisons and criminal justice system (Liebling et al., 2005). This, in turn, locates prisoner self-harm within a liberal, deontological discourse, which emphasizes the 'humanity' of all prisoners and hence their right to be treated with decency, respect and fairness, regardless of their alleged crimes. As argued by Carlen and Worrall (2004), to do so is not only 'justified in terms of "outcomes" (preventing suicide, reducing re-offending, and so on)', but, more importantly, is '*good in itself*' (emphasis in original, p. 50). Therefore, to research and 'care'

Feminism & Psychology © 2007 SAGE (Los Angeles, London, New Delhi and Singapore)
http://fap.sagepub.com, Vol. 17(3): 295–301; 0959-3535
DOI: 10.1177/0959353507079082

about the treatment and welfare of (all) prisoners is, in Byock's (2002) words, the 'right thing to do' (p. 107).

Initially, my focus on the humanity and 'fundamental' rights of prisoners – including, perhaps more controversially, the right to (safely) self-harm – meant overlooking questions around gender. Rather naively, I had assumed that this broad 'universal' framework could highlight issues of relevance to *all* prisoners, men and women alike. However, in the pursuit of 'originality', I decided to conduct my research with adult male prisoners, whose needs in relation to self-injury have received very little attention in the literature.

My liberal ideals and 'the tendency [for prison researchers] to downplay the emotional components of their research projects' (Bosworth et al., 2005: 259), had left me unprepared for my own feelings and reactions towards the 20 men I interviewed (many of whom had been remanded or sentenced for violent offences, including murder, rape and child abuse), and the several others I met during six months of fieldwork at a crowded local male prison in the South East of England. Throughout this time, I frequently felt angry, punitive, intimidated and even frightened. Often, all these feelings would come flooding in while walking on the landings or, worse, interviewing participants. These emotions are bound to have affected the ways in which I interacted with these men and the knowledge produced during the interviews, as well as my interpretations and representations of participants' stories and subjectivities.

Particularly when interacting with perpetrators of gendered violence, I became acutely aware that gender does indeed matter. Notwithstanding my concern for the human rights of male prisoners, what about *my* right not to feel sexually harassed? What about (male) staff's moral duty to take my concerns and personal safety seriously? This, in turn, prompted me to rethink the notion of 'universal' human rights and some of the liberal assumptions that had informed my work. Marxist, postmodernist, post-colonial and/or feminist theorists have critiqued these ideologies as gendered and bourgeois (for a recent review, see Richards, 2005). For instance, as exemplified by my own experiences at the prison, the concept of (hu)man rights fails to capture issues around women's security, both in public and private spheres (Caprioli, 2004). 'Far from benefiting the mass of humanity, in practice they reflect the values and interests of liberal capitalism' (O'Donnell, 2003: 756), tacitly reinforcing its systems and practices of oppression, including the patriarchal context within which liberalism evolved (Earth, 2005). Despite their presumed 'universality', human rights ideologies are arguably 'based on a prototypical male individual' and 'permeated with male supremacy' (Earth, 2005: 107–8). Therefore, and in the words of Caprioli (2004: 425), 'what is the goal of promoting . . . human rights if they typically apply only to [western, white, heterosexual, able-bodied, middle class] men?'

Feeling and demonstrating care, sympathy or concern for (some) male prisoners became increasingly difficult during my fieldwork. With hindsight, I believe this was partly due to my being influenced – as perhaps inevitable – by the prison's dominant values, customs and working practices, including its 'cult of

machismo' (Ryder, 1994). Moreover, this stage of my study seemed to coincide with my identifying more and more as a feminist. This, in turn, made me question the political starting-point of my research, its potential implications and the coherence (and incoherence) of my current personal – and thus political – convictions and academic work. The following section explores some of the tensions and contradictions of carrying out feminist research with and, in many ways, *for* men.

IS MY WORK 'FEMINIST' ENOUGH?

As contended by Orme et al. (2000: 93), 'why should women expend their energies on men who already receive a disproportionate share of social resources, when there is continuing work to be done with women to repair the damage done to them by men?' If to express concern about male pain, experience and 'crisis' (Coyle, 1998) 'smacks of apologia' (Hautzinger, 2003: 94) and risks ' re-excluding women' (Hearn, 2004: 50), how can I justify my research? Why am I focusing on the issues and 'rights' of male perpetrators of gendered violence, as opposed to those of 'survivors'? Above all, is my work 'feminist' enough? If so, 'what – beyond apologia – can we learn from [researching men]?' (Hautzinger, 2003: 95).

Negotiating these tensions depends, in great part, on how one defines 'feminism' and 'gender'. Arguably, the question of whether my work with men may constitute legitimate, 'good' and 'appropriate' feminism is misleading, if not meaningless, on at least two accounts. First, because there is no such thing as *a* unitary feminist theory or methodology; second, because the category 'man' is neither static nor monolithic. While the former argument has received extensive – and perhaps exhaustive – attention in the literature (e.g. Henwood et al., 1998), it may be useful to focus on the latter point, which was key to resolving many of the dilemmas described earlier.

RETHINKING AND 'UNDOING GENDER'

Post-structural feminist theorists have challenged essentialist notions of inherent gender differences, and brought attention to men and women's diverse, shifting and fragmented identities. Moreover, it has been argued that these multiple selves are not intrinsic to the subject, but are culturally and 'performatively constituted' (Butler, 1990), in situated and contested ways. This process of 'undoing gender' (Butler, 2004) has thus broken down 'the old, tidy binaries of difference and dominance, men and women, masculine and feminine' (Gardiner, 2002: 23–4). Within this framework, neat distinctions between male and female, powerful and powerless, are no longer relevant or desirable, particularly when one considers the simultaneity and intersectionality of gender and many other dimensions of

power and 'otherness' (Kitzinger and Wilkinson, 1996), including 'race', sexuality, disability and class. This, in turn, implies that not all men are necessarily (all) powerful and oppressive, nor can 'man' be equated with 'patriarchy'. Indeed, in virtue of their multiple positionings along such dimensions of power and powerlessness, and the ways in which patriarchy is intertwined with racism, heterosexism, classism and other systems of oppression, (some) men are also – at times – 'other', to women and, more often, to other men.

Arguably, to conduct 'feminist' work is not necessarily or exclusively to focus on unitary notions of 'woman', but to construct one's analysis in terms of power and power relations. In the words of Kitzinger (1991a: 112), 'feminism is, after all, a movement devoted to the transformation of unequal power relations'. This conceptualization of feminism, and a social constructionist view of gender, open up new and alternative possibilities, most notably that feminist research can – and arguably should – be carried out with both 'men' and 'women', and aim to expose, critique and challenge oppression, both within and across gender. As contended by Ashe (2004: 202):

> feminism needs to examine male experience as a category that generates different effects. It is by charting the effects of male experience that feminism can gain a fuller and more sophisticated understanding of the possibilities for men to reformulate their identities in non-oppressive ways.

In trying to reconcile my feminist politics with my academic work, I came to realize that the crucial point is perhaps not *what* or *whom* one might decide to research, but rather *how*. Hearn (2004), among others, has argued that the 'problem' is not researching (violent) men, but studying men as 'agendered, asexual, "neutral" adults, citizens or people' (p. 51). With this in mind, I resolved some of the conflicts that arose during my fieldwork by 'naming men [prisoners] as men' (Hanmer, 1990), and prisons as 'gendered organisations' (Carrabine and Longhurst, 1998). In so doing, I hoped to challenge the implicit assumption of 'malestream' accounts, that men are the norm from which women might deviate. Moreover, I aimed to draw as much as possible on feminist principles and methodologies, most notably the focus on reflexivity, the commitment to 'politicizing psychology' (Kitzinger, 1991b) and the rejection of 'objective', positivist 'scientific' methods.

Many feminists have also negotiated some of the tensions discussed in this article by aiming their work with men to be exclusively or predominantly for 'women's longer-term interests' (Orme et al., 2000: 93). I would argue, however, that it is not 'anti-feminist' to carry out research with and *for* men. Indeed, these outcomes – and associated gender categories – are by no means incompatible. For instance, there is now a growing body of feminist literature aiming to 'deconstruct and reconstruct areas that are problematic in relation to men' (Cowburn, 2004: 500), not only with regards to their (often) oppressive and violent relations to women, but also – at least apparently – out of concern for men's own health (e.g. De Souza and Ciclitira, 2006).

In relation to self-harm, much feminist psychological work has been conducted

in the context of a 'hegemonic struggle' with 'official' (male) psychiatry (Cresswell, 2005). The legitimate political quest to produce a hegemonic 'truth' of self-harm as a gendered issue has resulted in a wealth of research deconstructing dominant discourses around female self-harm. Unfortunately, this has meant that the cultural practices and discourses surrounding male self-harm have remained largely unexplored. Emphasizing that men *too* self-harm may bring benefits to (some) men, their partners, friends and family, and those – often women – who work and care for them. At the same time, focusing on male self-harm may generate emancipatory alternatives to the regrettably still popular construction of self-injury as a female pathology (Brickman, 2004). To conduct such work within the context of prisons is perhaps especially useful, not only in consideration of the high rates of self-harm in custody, but also because prison-based research has traditionally been 'gender segregated' (Bosworth et al., 2005).

Nevertheless, it would be naive of me to assume that this resolves all the challenges and dilemmas of conducting feminist research with and *for* male prisoners who self-harm. Indeed, the recognition that my research remains *primarily* concerned with the issues and 'rights' of men, as opposed to women, does, occasionally, come back to taunt me! Perhaps, had I been completely satisfied with the feminist 'legitimacy' of my work (whatever that means), I would not have decided to amend my original research plan to focus less on male prisoners, and more on male and female prison staff. Moreover, the decision to abandon a liberal human rights perspective in favour of a post-structural feminist framework raises further issues and debates, particularly with regards to structure and agency, politics and relativism, material 'reality' and subjective experience (see e.g. Burman, 1992).

Undoubtedly, identifying as a feminist *during* my research has raised many tensions and conflicts. However, feminist theories and methodologies have also suggested ways of resolving many of these contradictions, and, above all, continue to be a crucial source of reflection and inspiration on a personal, political and intellectual level. Furthermore, feminist psychological approaches have helped me to be reconciled not only to my work, but also to my identity as an academic and a 'psychologist'. Feminism is not just what I do; it is how I am.

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ACKNOWLEDGEMENTS

The research contained in this paper was funded by the Economic and Social Research Council (ESRC). The author is in receipt of a Full-Time Postgraduate Studentship, grant No. PTA – 30 – 2003 – 01573.

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International Journal of Prisoner Health, December 2007; 3(4): 268–282

ORIGINAL ARTICLE

Supporting staff working with prisoners who self-harm: A survey of support services for staff dealing with self-harm in prisons in England and Wales

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Abstract
Research has consistently shown that staff working with people who self-harm tend to experience a range of anxieties and negative emotions. Very little has been written on the particular issues and needs of staff in prisons, where rates of self-harm are high. The current study gathered information about existing sources of support for staff dealing with prisoners who self-harm, and identified positive practice examples. A postal survey was sent out to the Suicide Prevention Team Leaders from every HM Prison Service Establishment in England and Wales (139 in total). Fifty-four surveys (38.8%) were completed and returned. Findings indicate that staff support services were reportedly in place in virtually all 54 establishments. However, the data suggest that even when present, provisions may not have adequately met the needs of staff working with prisoners who self-harm, particularly when dealing with 'repetitive' self-harming behaviours. These findings are discussed in relation to organizational health literature. Their practical and theoretical implications are considered, together with directions for further studies in this under-researched area.

Keywords: *Self-harm in prisons, work stress, work stress management and prevention*

Introduction

Prison staff are often neglected in the literature surrounding self-harm in prisons (notable exceptions are Liebling, 1992; Liebling, Tait, Durie, Stiles & Harvey, 2005; Snow, 1997). Despite official recognition that 'self-injury is an enormously difficult behaviour to manage and to work with' (WHO, 2000: 11; see also HM Chief Inspector of Prisons, 1999), there has been very little prison-based research on the experiences, reactions and needs of staff dealing with this issue. The relative lack of publications in this area is particularly disheartening considering the high rates of self-harm in custody (see e.g. Safer Custody Group, 2004), and the crucial role that staff play in the prevention and management of prisoner suicide and self-injury (e.g. Dexter & Towl, 1995; Power 1997; Rowan, 1994). Moreover, as staff are the ones who most often discover and deal with self-harm in prisons,

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ISSN 1744-9200 print/ISSN 1744-9219 online
DOI: 10.1080/17449200701682501

their welfare must be also considered. Understanding their needs and offering suitable training, support, and supervision may reduce staff stress and burnout (Bowers, 2002; Burrow, 1992), contribute to creating a supportive environment for those at risk of suicide and self-harm (Liebling & Chipcase, 2001), and generally enhance the regime (Adler, 1999; Liebling, Price & Elliott, 1999). Helping staff to cope with this potentially stressful area of work may also have benefits for the National Offender Management Service[1] (NOMS) in terms of reducing staff sickness and turn-over rates (Bailey, McHugh, Chisnall & Forbes, 2000).

The meaning of 'self-harm' is open to debate. Discussion of definitional problems is arguably too long and complex to debate fully in this context (for a review see Crighton & Towl, 2002). For consistency in dissemination, we have used the Prison Service definition. Unless otherwise specified, the term 'self-harm' is used to describe 'any act where a prisoner deliberately harms themselves, irrespective of the method, intent or severity of any injury' (HM Prison Service, 2003a: para 3.1.1). Nevertheless, clinical and prison-based literature suggests that different types and levels of self-harm should be distinguished. In particular, that repetition of self-injury and (*apparent*) suicidal intent should also be considered (e.g. Pannell, Howells & Day, 2003; Snow, 1997). Therefore, these dimensions, associated *types* of self-harm, including that with suicidal intent, are also taken into account.

Applied psychological literature regarding professionals' reactions and responses to self-harm suggests that working with people who self-harm is a potential source of staff stress, burnout, and trauma (see e.g. Crawford, Geragthy, Street & Simonoff, 2003; Fish, 2000). Therefore, we turn now to the organizational health literature to try to identify interventions likely to reduce the strain of prison staff dealing with self-harm.

Work stress prevention and management

There are at least three levels of intervention that can be implemented to prevent and manage stress in the workplace (see e.g. Murphy, 1996). 'Primary' measures aim to reduce or eliminate the sources of stress in the work environment, by manipulating the 'context' and/or the 'content' of work (Cox, 1993). For example, and specifically in relation to self-harm, this may involve a variety of changes in the design and management of work (from increasing staffing levels and employees' participation in decision-making, to promoting open communication and good staff-management relations), as well as strategies to reduce and/or prevent the incidence of self-harm, develop a supportive organisational culture and address potential issues of role conflict and ambiguity. Despite being often considered the most sensible, effective and ethically desirable area for intervention (Highley-Marchington & Cooper, 1998; Mackay, Cousins, Kelly, Lee & McCaig, 2004), primary measures are rarely used (Jones & Bright, 2001), particularly when they may be met by strong cultural resistance, and be quite costly (Parkes & Sparkes, 1998).

'Secondary' interventions are designed to diminish the effects of stress on employees, by increasing individuals' abilities to cope with stressors. This typically incorporates skills training. Although critics have argued that these measures do not address the *sources* of stress at work (e.g. Murphy, 1984), recent evidence suggests that secondary interventions can have small, but significant effects on staff well-being, at least in the short term (for a review see Jones & Bright, 2001). Furthermore, it may be argued that some secondary measures, such as mental health awareness training and clinical supervision, may not only help staff to *cope* with and contain stress, but can also reduce the likelihood of individuals experiencing stress, trauma or burnout (e.g. Mitchell, McClay, Boddy & Cecchi, 1991).

'Tertiary' interventions are primarily concerned with the recovery and rehabilitation levels. However, evidence of their effectiveness is mixed. For example, Bisson, Jenkins, Alexander and Bannister (1997) reported disappointing effects, whereas Cox (1993) found more positive effects. Nevertheless, Employee Assistance Programmes (EAPs) have been shown to have positive effects both for individuals and organizations in terms of reducing absenteeism, accidents, injuries and grievances (e.g. Cooper & Sadri, 1991). In addition, it has been suggested that cognitive-behavioural therapy may be effective in treating symptoms of Post-Traumatic Stress Disorder in staff dealing with the aftermath of a 'suicidal' incident of self-harm and/or a self-inflicted death in custody (see e.g. Borrill, Teers, Paton, Regan & Cassidy, 2004). However, on their own, tertiary level interventions are unlikely to satisfy employers' duty of care to staff, and may amount to little more than a short-term 'sticking plaster' (Highley-Marchington & Cooper, 1998; Parkes & Sparkes, 1998).

Current thinking on occupational health and safety emphasises the need for comprehensive approaches to stress amelioration. For instance, and specifically in relation to self-harm, Burrow (1992) argued that:

> staff could be assisted by more theoretical knowledge, and understanding, of self-injurious motivations reinforced with in-service training, group discussions, clinical supervision, staff selection, staffing procedures and an awareness of signs of 'burnout' (p. 147).

A further recommendation is that stress prevention and management strategies should be tailored to the needs of individual organisations and employees (Mackay et al., 2004; Rick, Thomson, Briner, O'Regan & Daniels, 2002). The next section, therefore, turns to discussion of current support provisions for staff in prisons in England and Wales. Please note that we use the general term 'staff' to denote all types and grades of staff employed within Prison Service establishments (unless otherwise specified).

Current practice

Liebling (1992) commented that the lack of interventions to support staff dealing with suicide and self-harm in prisons was:

> one of the major oversights of current procedures ... everyone else's needs are taken into account ... Officers and other staff felt that they were just expected to cope (p. 202).

Significant progress seems to have been made since then and the Prison Service officially recognizes its duty to provide 'support for the staff who care for prisoners at risk of suicide and self-harm' (HM Prison Service, 2003a). For this purpose, there is a national Staff Care and Welfare Service (SCWS), as well as local care teams in each establishment. Amongst other duties, they organise critical post-incident debriefs and refer staff for counselling (see HM Prison Service, 1998, 2004). However, these provisions are only activated following a self-inflicted death or a 'serious' incident of self-harm. Moreover, critical incident debriefs are not currently mandatory, taking place only if 'requested by Governors' (HM Prison Service, 2004).

Previous research suggests that these services are often under-used, and that staff views are diverse about their efficacy, confidentiality and practicality (Borrill et al., 2004; Liebling & Price, 2001). Indeed, the prison context presents particular difficulties to the effective support of staff dealing with self-harm. Like many large, public institutions, constant

pressures on resources and staff time mean that regular training, supervision, de-briefing, group and one-to-one support are often not practical. In England and Wales, this situation is exacerbated by widespread prison overcrowding and the growing number of 'vulnerable' people in custody (Joint Committee on Human Rights, 2004). In addition, prison staff operate within a culture that does not encourage the direct expression of emotions (Arnold, 2005; Towl & Forbes, 2002), with the implication that staff may feel reluctant to accept or seek support.

Local care teams and the SCWS are not specifically designed to support the needs of staff following a self-inflicted death or an incident of self-harm, nor are they necessarily the only provisions available to staff in these circumstances. Whilst the implementation of clinical supervision 'remains patchy and lacks a systematic strategy' (Freshwater, 2005: 56), and is almost exclusively aimed at healthcare staff (rather than 'all staff ... providing treatment and care for people who have self-harmed' (NICE, 2004: para 5.5.1.2)), recent years have seen the development of a new staff training package specifically on self-harm and a one for mental health awareness for prison staff (Musselwhite, Freshwater, Jack & Maclean, 2004). The Safer Custody Group has also developed posters conveying key messages about self-harm, and a detailed booklet containing information and guidance for staff on working with prisoners who self-harm. Unfortunately, none of these measures, nor the 'standard suicide [and self-harm] prevention training' (Liebling et al., 2005: 194) for staff, are currently mandatory (see HM Prison Service, 2003). Moreover, there is evidence that staff availability to attend and/or be released for training is considerably restricted, particularly, and perhaps paradoxically, in establishments with high rates of self-harm (ibid.; see also Offender Health Care Strategy, 2006).

Nevertheless, it should also be noted that much positive informal work is carried out by a variety of staff and departments across the prison estate (and the rest of NOMS) (HM Chief Inspector of Prisons, 1999; Howard League, 2001, 2003). However, as noted by Cutler, Bailey and Dexter (1997), a number of good initiatives remain isolated in individual establishments. These initiatives, however, are not utilized throughout the system nor are they used to develop future services. With this in mind, and following consultation with the Safer Custody Group,[2] this study aimed to:

a. gather information about what types and levels of interventions exist to support prison staff dealing with self-harm; and
b. identify positive practice examples.

Methods

Sample

A postal survey was sent out to every HM Prison Service Establishment in England and Wales (139 in total). Fifty-four surveys (38.8%) were completed and returned. The sample was fairly representative of the prison estate in England and Wales. Most responses (almost 70% of the total sample) came from adult male establishments, particularly category[3] B local and category C prisons; 15% from female establishments and again 15%, from young offender institutions (YOIs). Table I describes the make up of the current sample by establishment type.

One establishment in the current sample was located in Wales; the remaining 53 were spread relatively evenly between Southern, Mid and Northern England. Three of the 10 privately run establishments in England responded to the survey.

Table I. Breakdown of sample by establishment type.

Establishment type	*N*	Percentage in sample
Category C	12	22.2
Category B Local[1]	9	16.7
Female[2]	8	14.8
Young Offender Institution (YOI)[3]	8	14.8
Category B	6	11.1
Open	3	5.6
Dispersal[4]	3	5.6
Resettlement[5]	3	5.6
Immigration Removal Centre[6]	1	1.9
Category B Local+YOI	1	1.9
Total	54	100

[1]Local Prisons deal with men and young offenders who are sent directly from the courts, either when remanded in custody before trial or after conviction or sentence. These establishments can hold prisoners for the duration of their sentences, or only for the initial assessment and classification of convicted prisoners before their allocation for another prison to serve their sentences.

[2]Female establishments hold adult and young women prisoners. Please note that juvenile and young female offenders are not held in separate YOIs (as are young males), but in 'partly designated YOIs' within particular adult female establishments (Leech & Cheney, 2000). For this reason, and given the relatively low number of young and juvenile female offenders held in custody, it is customary to consider the female prison estate as a whole, rather than to make distinctions between young offender institutions and adult prisons, as is the case with the male population.

[3]Young Offender Institutions (YOIs): YOIs hold young prisoners under the age of 21. Please note that, for the purposes of this study, the terms 'YOIs' and 'young offender' will be used, respectively, to denote *male* establishments and *male* offenders in YOIs (i.e. excluding 'young adult offenders' held in adult male prisons; see Leech & Cheney, 2000). Young female offenders and establishments will fall under the wider categories of 'female prisoners' and 'female establishments'.

[4]Dispersal Prisons: 'High security' establishments operating 'maximum security' conditions.

[5]Resettlement Prisons are establishment holding prisoners nearing the end of a long sentence.

[6]Immigration Removal Centres are establishments holding unsentenced immigration detainees for the Immigration Service.

Participants

The survey was mailed out to the Suicide Prevention Team Leader (SPT leader) in each establishment. Although Governors and Directors have overall responsibility for the implementation of suicide and self-harm prevention strategies within their establishments, much is delegated to SPT leaders who are appointed to chair regular 'Suicide [and self-harm] Prevention' meetings and hold key responsibilities for the implementation and development of local policies and procedures. Thus, they were deemed the most appropriate people to approach for responses.

Please note that SPT leaders may be drawn from any grade or discipline, are said to have training available to them to fulfil this role, and 'can be supported by a deputy team leader and/or a Suicide Prevention Co-ordinator' (where available) (HM Prison Service, 2003a: para 1.5). Frequently, SPT leaders are also their establishments' Suicide Prevention Co-ordinators.

Materials

An 11-item, semi-structured, self-completion questionnaire was designed in consultation with the Safer Custody Group. The questionnaire utilized open and closed questions

addressing issues around support for staff working with prisoners who self-harm. In particular, respondents were asked whether their establishments offered any formal or informal interventions to support staff dealing with prisoner self-harm. If so, they were invited to specify what these were, and whether they considered any of these interventions to be 'good practice'. Participants were also asked whether they were aware of any good practices or schemes operating elsewhere to support staff working with prisoners who self-harm and, if applicable, to specify what these were. This was designed both to try to provide potentially useful data about prisons that may have declined to submit a response, and to gain some indication about the flow of information between establishments.

For individual institutional context, questions were included about population sizes; levels of overcrowding[4]; security classifications (see endnote iii); number of self-inflicted deaths and incidents of self-harm, 'repetitive' self-harm (defined in the survey as 'incidents by prisoners who repeatedly self-harm') and 'suicidal' self-harm (broadly defined as acts committed by prisoners who 'intended to commit suicide') occurring in each establishment in the 12 months prior to the research.

Procedure

In January 2004 the survey was mailed out simultaneously to all Suicide Prevention Team Leaders in England and Wales. Participants were asked to answer all questions as fully as possible, and to return the completed questionnaire using an enclosed pre-paid envelope. Every questionnaire was sent out with an information sheet clarifying the purpose, methods, and intended or possible uses of the research. This was to assure potential participants about the confidentiality of their answers and to satisfy data protection requirements.

Ethical issues

Given their roles within their establishments, there are clear ethical implications in asking Suicide Prevention Team leaders about the nature and the quality of services offered to their staff. In the context of prisons' 'performance culture' (Liebling & Price, 2001), respondents may feel 'under accusation', and be rather cautious, or reluctant participants in the research process. In addition, it is possible that respondents themselves may have had negative experiences of dealing with self-harm; they too may self-injure, or may be close to someone who does. As a result, some respondents may feel especially uncomfortable about discussing these issues.

For these reasons, a number of steps were taken to ensure the ethical acceptability of the current study. Prior to conducting this research, formal ethical approval was sought from the Psychology Ethics Committee at Middlesex University, and what was then the Prison Service's (now NOMS) Applied Psychology Group. This project was conducted in strict compliance with the Ethical Guidelines set by the British Psychological Society (and Division of Forensic Psychology).

Results

Eighteen (35%) establishments in the current sample were deemed to be overcrowded, whereas the remaining 34 (65%) had Certified Normal Accommodation (CNA) levels higher than (or equal to) their Average Annual Populations (AAPs). The sample displayed considerable variation in the numbers of self-inflicted deaths (ranging from none to five) occurring within individual establishments in the twelve months prior to the research.

In almost half the establishments surveyed (23, 43%), at least one death had occurred within the time period under consideration. The number of self-harm incidents in each establishment also varied (min = 0, max = 1418, mean = 192.3, standard deviation = 286.4; mean rate per 1000 prisoners[5] = 585.9 (standard deviation = 1101.6)), as were the total number of acts of 'repetitive' (min = 0, max = 1134, mean = 110.6, standard deviation = 228; mean rate per 1000 prisoners = 311.8 (standard deviation = 740.6)) and 'suicidal' self-harm (min = 0, max = 61, mean = 5.5, standard deviation = 11.6; mean rate per 1000 prisoners = 17.3 (standard deviation = 61.7)).

Interventions to support staff working with prisoners who self-harm were in place in the majority of establishments in the sample (49, 90.7%). In many cases (22, 40%), respondents provided details of only one service or intervention. A fifth of respondents (11) mentioned two such interventions, 13 (24%) cited three, and only two (3.7%) mentioned more than three staff support services. Only one establishment in the current sample appeared to have no services in place to support staff dealing with self-harm. This was a resettlement prison in which no incident of self-harm had taken place 'in years'.

Further variations were observed with regards to the types and levels of support interventions available within individual establishments (see Table II). Consistent with the organizational health literature, these were classified as primary, secondary and tertiary. As can be seen, primary interventions included job role(s) and demands, control, support (peer and managerial), and relationships at work. Secondary levels included measures to increase knowledge and awareness of self-harm and/or its potential effects on staff. Post-incident treatment interventions were classified as tertiary.

Table II demonstrates that tertiary-level interventions were reported over 10 times more than primary- and secondary-level services. Individually focused, tertiary-level interventions

Table II. Type and level of interventions to support staff working with prisoners who self-harm available within individual establishments (with frequencies).

Type and level of intervention	*N*
Primary interventions	
Management support	4
Informal support from colleagues	3
Staff Sensitivity Meetings	1
Quarterly Suicide Prevention Meetings	1
TOTAL	9
Secondary interventions	
Safer Custody Group	3
Suicide prevention training	2
Self-harm 'pocket guide'	1
Informal advice on dealing with self-harm	1
TOTAL	7
Tertiary interventions	
Local Care Team	42
Staff Care and Welfare Service	26
Samaritans	8
Staff Counselling	6
Care First	6
Debriefing (following 'serious' incidents')	3
Informal support with in-reach team (post-incident)	1
Informal 'off-loading' sessions/diffusing	1
TOTAL	93

appeared to be used exclusively in almost 70% of participating establishments ($n = 37$). Nine institutions (16.7%) adopted strategies at both primary- and tertiary-levels of intervention, whilst eight (14.8%) provided secondary and tertiary programmes. No establishment in the current sample reported offering a combination of primary, secondary and tertiary measures to support their staff in dealing with prisoners who self-harm.

'Standard' vs. 'extra' provisions

The staff support services most frequently mentioned by respondents were local care teams (42, 77.8%) and the Staff Care and Welfare Service (SCWS) (26, 48.1%), both of which are tertiary-level interventions. These were described by some respondents as 'standard provisions that are available in all establishments'.

Only 19 respondents (35.2%) cited support services other than the 'standard' interventions required by Prison Service policy. The majority (42, 78%) of establishments offering 'extra' interventions were reported to operate good practice in supporting staff dealing with prisoner self-harm. Establishments that had suffered at least one self-inflicted death in the year prior to the research were significantly more likely to offer 'extra' staff support services ($\chi^2 = 5.6$, df $= 1$, $p < 0.05$; Likelihood ratio $= 5.7$, df $= 1$, $p < 0.05$). However, the strength of association between these two variables was not significant ($\lambda = 0.2$).

Samaritans

The Samaritans' involvement in supporting staff was considered to be good practice by all eight SPT leaders who mentioned their work. For example, one respondent remarked that, whilst 'staff are reluctant to speak to "other staff" for various reasons ... the Samaritans are gradually becoming more and more accepted and staff will approach them'. In the majority of cases, the Samaritans were described as providing support following a 'serious' incident of self-harm and/or a self-inflicted death. It was unclear from participants' responses whether the Samaritans also supported staff dealing with prisoners who repeatedly self-harm and/or those whose self-harming behaviour is not deemed to be 'serious'.

Care First

Six respondents (11.1%) referred to Care First, an 'Employee Assistance Solution' offering professional counselling and information over the telephone. This was described as an independent and confidential '24/7 telephone service', available to staff dealing with any domestic or work-related issue. Five of the six responses identified Care First as an example of good practice.

Staff counselling

Facilities for face-to-face staff counselling were mentioned by six respondents (11.1%). In particular, three of these cited a post-incident counselling referral service available through the SCWS (a facility provided to all Prison Service establishments). In addition to this service, one respondent from a YOI mentioned the involvement of nursing staff counsellors in providing support for staff working in this difficult area. A medium secure (category B) local prison and a female local establishment, with the highest rate of self-harm in the whole sample, were reported to run regular on-site staff counselling services, described as free, independent and confidential. Both were highlighted as examples of good practice.

Information, advice and training

The provision of information, advice and/or training on self-harm was also cited as a strategy to help staff cope with this demanding area of work. In contrast to post-incident support interventions (such as 'off-loading sessions' and 'critical debriefings'), these were considered to be *preventative* sources of support, that 'equip staff to deal with and manage such prisoners'.

Support from colleagues and managers

Support from colleagues and managers in suicide prevention team meetings were specifically mentioned by 17% of respondents (this figure does not include the 42 respondents (78%) who cited local care teams, which also offer practical and befriending peer support). In most cases, this support was described as 'informal'. Only one establishment was found to operate a formalized weekly 'Staff Sensitivity Group'—aimed at offering supervision, as well as support, to all staff. These group sessions, generally run by a therapist or by the psychologist(s) on the wing, were described as an opportunity for staff to discuss prison-related stress, and, less often, to focus on domestic issues. It was suggested that, 'in the long run', a therapeutic approach would prove to be 'cost-effective' in any prison.

'Good practice'

When asked whether any of the staff support services operating within their establishments could be classed as good practice, the majority of respondents provided a positive answer (30; 55.6%). This frequency of responses, however, is only slightly above chance.

Attributions of good practice were found to be independent of rates of self-inflicted deaths ($r=0.2$, $p>0.05$), self-harm ($r=0.1$, $p>0.05$), 'repetitive' self-harm ($r=0.03$, $p>0.05$) and 'suicidal' self-harm ($r=0.15$, $p>0.05$).

Good practices or schemes in other establishments

Only four respondents (7.4%) were aware of good support practices or schemes operating in establishments other than the ones in which they worked to support staff working with prisoners who self-harm. 'Training/advice from mental health professionals', and 'counselling' were both singled out as examples of good practice.

Discussion

The results of this study would suggest that there is a paucity of interventions specifically designed to help staff deal with prisoners who self-harm. The vast majority of interventions mentioned by participants (including local care teams, the Staff Care and Welfare Service (SCWS), Care First and other forms of post-incident counselling) offer support for a variety of issues (e.g. domestic problems, debt management and fear of assaults) and/or are not primarily conceived or employed as a source of support for staff dealing with self-harm (e.g. the Samaritans). This is fairly common in organizations; many secondary and tertiary interventions can be (and usually are) standardized (Jordan, Gurr, Tinline, Giga, Faragher & Cooper, 2003). What is arguably more problematic is that many respondents did not identify services such as the SCWS as interventions to support staff working with prisoners who self-harm. If Suicide Prevention Team leaders (who are supposedly better informed

about these issues than most members of staff in their establishments) do not view these 'generic' interventions as potential sources of support for staff working with self-harm, what likelihood is there that such staff would use them?

As in most organisations (Parkes & Sparkes, 1998), the vast majority of interventions implemented within the Prison Service to support staff dealing with self-harm are 'concerned with changing the worker as opposed to work or the work environment' (Cox, 1993: 66; see also Lambert, 2004). Although there were examples of all three levels of intervention identified within the occupational health literature (e.g. Murphy, 1996), most of the programmes described by respondents were tertiary provisions for *post-incident* care, thereby apparently avoiding measures designed to eliminate or modify workplace stressors (Rick et al., 2002).

Whilst there may be some advantages in offering staff this type of support following an event as (relatively) rare as a self-inflicted death or an attempted suicide (for recent reviews of the impact of a death in custody see Borrill et al., 2004; Snow & McHugh, 2002; Wright, Borrill, Teers & Cassidy, 2006), it is impractical to implement this kind of intervention after every incident of 'repetitive' self-harm in prisons. The on-going nature of this problem suggests that a broader and more proactive approach is needed to support staff dealing with this particular type of self-harm. In the words of McCarthy (2003), 'this support must be regular ... holistic and tailored' (p. 24). Unfortunately, very few establishments were identified as offering regular systems of support and/or 'preparing' staff to prevent, manage and deal with the aftermath of self-harm. Two respondents reported staff training, and only one mentioned the availability of regular group supervision.

Nevertheless, provisions for post-incident counselling were also identified by many respondents as good practice, especially when 'regular', 'formalised' and 'independent' of the Prison Service. As contended by Clark (2002), one-to-one or group counselling may give staff an opportunity to 'reflect on their own emotional reactions to self-harm' (p. 788), which is crucial to avoid staff burnout and create a supportive environment for prisoners at risk of suicide and self-harm (Liebling & Chipcase, 2001). In addition, the 'independent' nature of these interventions may satisfy staff concerns over confidentiality and their documented reluctance to speak to other staff about issues which may compromise a 'macho' image (Borrill et al., 2004). Formalizing these systems may also increase employees' feelings of support from management (Rick, Young & Guppy, 1998), hence be seen as 'a step towards recognizing the problems faced by staff, and reducing the perceived "blame culture"' (Fish, 2000: 205).

However, there is considerable agreement that, when used in isolation—as appeared to be the case in almost 70% of the establishments taking part in this research, tertiary interventions are both ineffective and 'ethically questionable' (Gangster, Mayes, Sime & Tharp, 1982). As contended by Parkes and Sparkes (1998):

> they do not meet the more general point that employees should not be required to adapt to work environments that impose unnecessary, excessive, or inappropriate demands (p.1).

Although approximately 50% of respondents identified the interventions operating within their establishments as representing good practice, the wider literature on tackling stress in the workplace would suggest otherwise. Given the multi-faceted nature of stress, many have argued that support strategies should not focus on a single type of intervention, but rather incorporate a whole 'package' of measures aimed at various levels of the organization, and different stages of the stress process (e.g. Jones & Bright, 2001). However, not one of the

establishments in the current sample appeared to offer a combination of primary, secondary and tertiary measures to support their staff in dealing with prisoners who self-harm, and relatively few used more than one type of approach. Thus, it may be argued that interventions identified by respondents as constituting good practice are perhaps best described as key *elements* of positive practice, rather than overall good strategies.

Limitations of the study

The findings of this study need to be interpreted with some caution. Firstly, and although a response rate of nearly 40% may be considered satisfactory for a postal survey, the sample was relatively small, and may not have been representative of the prison estate with regards to the support interventions offered to staff. Also, the respondents' subjective interpretations of what may or may not constitute good practice are inevitably varied. This, in turn, suggests that inconsistencies in the type and quality of support provided to staff in different establishments may not necessarily, or not exclusively, reflect differences in practice, but may also be indicative of different conceptualizations of the nature of a good intervention.

Furthermore, when asking about sources of support for staff dealing with self-harm, the researcher did not specify whether this study was concerned with self-harm *in general*, or with a particular *type* of self-harm. Given that prison staff tend to distinguish between different kinds of incidents (Pannell, Howells & Day, 2003; Snow, 1997), it is possible that participants' responses were relevant to different contexts and situations. In addition, respondents were given limited guidance as to how 'suicidal' self-harm was to be conceptualized or measured, and were asked to make judgments about suicidal intent, a notion that is notoriously fraught with difficulties (see e.g. Fairbairn, 1995; HM Prison Service, 2001). Clearly, this makes it difficult to compare their answers, and limits the validity and reliability of the current research. The use of more 'semantically accurate' and 'clearly defined' terms (Crighton & Towl, 2002, p. 51) might have prevented these problems, and, as such, is something that future research and policy should consider.

We should also consider use of the word 'support' to refer to interventions aimed at staff dealing with prisoner self-harm as it may have biased participants' responses toward post-incident, tertiary-level strategies. 'Support' is perhaps more commonly associated with the idea of 'reaction, rehabilitation and cure' (Cox, 1993: 63), and may fail to capture the notion of 'stress management' in its broadest sense (i.e. as encompassing both stress prevention and management; see e.g. Jordan et al., 2003). Failure to ask respondents about broader measures to promote good management practice may have led to under-reporting of some broader, primary interventions that are relevant to staff needs when dealing with self-harm. It is possible that even if present, respondents failed to identify establishments' self-harm prevention programmes (including staff training) as potential primary interventions for staff. Therefore, it would have been useful to ask participants to also comment on their establishments' broad approach to stress prevention, and to have included in the survey a list of relevant interventions.

Directions for further research

Despite the limitations of this study, the findings suggest there is scope for a number of follow up studies. Arguably, this subject needs to be examined separately to the matter of staff dealing with prison suicides, since the issues that may be specific to working with self-harm could be eclipsed by the priority given to suicides in custody. Moreover, future research in this area should explore the issues and needs of different groups of staff dealing

with prisoners who self-harm. Not all staff have the same level of contact with prisoners who self-harm, which suggests that different groups may be affected by this issue in different ways.

More research is also needed to identify staff support strategies which are both helpful and practical in the prison context. Adding strength to this conclusion are the findings from the 2006 Prison Service Staff Survey, suggesting that less than half (48%) of all responders agreed with the statement: 'the level of care provided to staff following an incident of suicide or self-harm at this prison is good' (Home Office, 2007: 1). Consulting directly with staff and key 'experts' (from the Prison Service, academics and clinicians) about their views and suggestions, may be a useful way of answering questions around the use, effectiveness and potential value of different interventions. Conducting an international survey of support services for staff dealing with self-harm may also provide some useful suggestions and positive practice examples, and may help to address the current lack of comparative literature in this area. In addition, further studies should explore the current and potential effects of appropriate support on staff welfare, and on the overall rates of suicide and self-harm amongst prisoners.

In the words of one respondent:

> in a very difficult environment marvellous work is conducted by dedicated and caring people. It is essential that their efforts are mentioned and recognised, so that the momentum continues.

Nevertheless, the findings of this, and previous studies suggest that there is still considerable scope for improvement in the support of staff dealing with self-harm in prisons, particularly with regards to 'repetitive' self-harm.

Notes

1 In June 2004, the Probation and Prison Services in England and Wales were merged to form NOMS (National Offender Management Service).

2 The Safer Custody Group, Prison Service HQ, was established in April 2001 with the aim to 'reduce the incidence of suicide and self-harm by developing broadly based policies to make prisons safer places in which to live and work' (HM Prison Service, 2001: para 6.1).

3 Following the Mountbatten Report (1966), all adult male prisoners in England and Wales are classified on reception and placed into one of four security categories based on their likelihood of escape, and the risk to the public should they escape. The category of prison reflects the security classification of prisoners held in any particular establishment. These security categories are defined as follows:

- Category A: 'Prisoners for whom escape would be highly dangerous to the public, or to the police, or to the security of the nation (Cat A = *Maximum security conditions*)'.
- Category B: 'Prisoners for whom the very highest conditions of security are not necessary, but for whom escape must be made very difficult (Cat B = *Closed conditions*)'.
- Category C: 'Prisoners who cannot be trusted in open conditions but who do not have the will or resources to make a determined escape attempt (Cat C = *Semi-open conditions*)'.
- Category D/'Open Prisons': 'Prisoners who can be trusted to serve their sentence in open conditions'. (Taken from Leech & Cheney, 2000: 237.)

Please note that female prisoners and young offenders are not subject to the same security classification (except those that are classified as Category A), but are classified as suitable for either open or closed conditions.

4 Approximate levels of overcrowding were calculated by subtracting each establishment's Average Annual Population (AAP) (the average number of people held in any particular establishment over a 12-month period) from its Certified Normal Accommodation (CNA) (the 'ideal' number of prisoners to be held in any particular

establishment (Leech & Cheney, 2000)). Establishments in which the CNA was higher than, or equal to the AAP were considered not to be overcrowded, whilst those establishments in which the AAP was higher than the CNA were classed as overcrowded.

5 When making comparisons between different prisons and groups of prisoners, the use of standardized rates is considered to be preferable to simple numbers, as 'it eliminates any effects caused by changes in the overall prison population' (Safer Custody Group, 2002: para. 3.4.2). Rates (per 1000 prisoners) of self-inflicted deaths, self-harm, 'repetitive' self-harm and 'suicidal' self-injury were therefore obtained, using the AAP as a denominator (for a more detailed discussion of the advantages and disadvantages of using standardised rates, and employing the AAP as a denominator, please refer to Safer Custody Group, 2002).

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If I am woman, who are 'they'? The construction of 'other' feminisms

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Characterisations of feminist identities are presented, represented and, arguably, misrepresented within current public debates and popular media. Issues of sameness and difference have come to the fore as both timely and politically relevant. This paper aims to address issues arising from engagement with feminisms, in particular those which we experience as 'other' but which, concurrently, resonate with many of our concerns. Conflicting views revolve around the viability of constructing stable political identities for women who elect to include the term 'feminist' in their self-description. These debates become increasingly complex when contextualised within relative power positionings of knowledge production in differing arenas. Drawing on the literature around the legitimisation of gender and political identities, the authors reflect in this paper on the possibilities of engaging with these identities, both in our capacity of 'others', but also as individuals whose theoretical positioning resonates with the issues under consideration.

Keywords: Othering, sameness, difference, identities, commensurabilities.

To begin with: Who are we?

THIS ARTICLE IS THE PRODUCT of informal meetings and discussions between the four authors. The series of debates that ensued between us were borne out of discussions of the potential possibilities of forging workable political relations between Western and non-Western feminisms. In the course of these conversations the debate extended to questions of whether we can or should engage with multiplex strands of feminist thought within the broad category of feminism more generally and how such an engagement might be played out. Our discussions of the question put forward in the title became increasingly complex as the similarities and differences between the perspectives of each of the authors became apparent.

Whilst we, the authors, would broadly describe ourselves as Western feminists, there are innumerable points of convergence and divergence between our theoretical standpoints. Moreover, we are similar and we are different along a number of fault lines. For example, two of the authors are in their 20s and two of the authors are in their 40s. There are also a number of connections as well as differences between all four of the authors in terms of ethnic background. However, three of the authors would broadly describe themselves as white and one author would refer to herself as of mixed 'race'. The ways in which aspects of our experiences intersect and diverge further illustrates this point. For example, we all work in psychology departments but we are all at different stages in our careers. Through our discussions of this question we became increasingly engaged with each other and concerned with understanding our resonances and differences. Our attempts to engage with the question proposed underscored the ways in which our attempts to engage with each other are always already framed within varying dimensions of similarity and difference.

The question that we ask in the title has already received serious attention within the academic and feminist literature. However, given the range of views and the differing ways in which each of us could be represented, we found it productive to explore this complex subject further through the written medium. In this article we aim to address issues arising from engagement with feminisms, in particular those feminisms which we experience as 'other' but which, at

the same time, resonate with many of our concerns and understandings. In engaging with this question, we aim to trace a path through the debates and highlight how we have sought to engage with these as a group rather than solely as individuals.

Feminist identities

Characterisations of feminist identities are presented, represented and, arguably, misrepresented within current public debates and the popular media. In spite of the many dominant discourses in our culture that conceptualise 'feminist' as a stable and essential identity, be it a favourable or (more often) an unfavourable one, feminism is not monolithic. The diversity of dialects of feminisms makes it difficult for us to conceptualise feminism in the singular at all (Hemmings, 2005). To construct a watertight definition would be exclusionary whereas a definition with too few descriptions could render the term meaningless (Allwood & Wadia, 2002). Moreover, and particularly over the past decade, the tensions and conflicts between feminist positions have made it hard, if not impossible, to define not only what feminism is, but who a feminist might be.

The increasing heterogeneity of feminist identities has developed not just as a continuum along the political spectrum, but in the form of differences – and often divisions – along generational, ideological and religious lines (e.g. Johnson, 2002). Moreover, many of these differences are constructed along dimensions of power (see, for example, Burns, 1999) and frequently expressed in terms of binary oppositions (e.g. white/black, heterosexual/lesbian, first world/third world, and so on). Neither 'white' feminism nor 'black' feminism are essentialist categories (nor are they in opposition); rather, they are fields of contestation inscribed with discursive and material processes and practices in a post-colonial terrain (Brah, 1996, p.111). Feminism is only ever prefixed by 'white' when it is being problematised: most of the time its whiteness is rendered invisible by its universalist pretensions (Young, 2000, p.50). The various instantiations of feminism do not simply reflect the extent of diversity between women, but the power differentials and inequalities that exist therein (e.g. Byrne, 2003). As Sherna Berger Gluck and Daphne Patai (1991) argue, 'we must not assume that gender unites women more powerfully than race and class divides them' (p.2).

The multiple positionings within feminism raise a number of questions, not least of which is how feminism can engage with relevant 'each' others. Diane Richardson (1996) argues that variation is such that feminists have begun to locate alternate positionings within 'feminism' precisely as feminist 'Others'. Sue Wilkinson and Celia Kitzinger (1996) describe the almost paradoxical situation whereby 'Western academic feminists, committed to the articulation of what is Other in relation to patriarchal male values, now have to confront the challenge of other Others for whom they themselves constitute a new hegemony, and in relation to whom they stand in positions of power and domination' (p.7). The relationships between feminists around these issues at local, national and international levels have been so tense as to cause Lynne Segal (1999) to speak of 'feminists even frightening each other' (p.9).

Within this context, the theoretical and political difficulties of according authority to (other) feminisms, and the processes and discourses by which feminist behaviours and ideologies are constructed as legitimate and 'appropriate' (Ussher, 1991) become relevant. There are conflicting views about the possibility of constructing recognisable and stable political identities for women who elect to include the term 'feminist' in their self-description.

I am 'woman'?

One response to the issue of difference between feminisms has been the development of unifying or totalising strategies. It is argued that unity amongst women is desir-

able and perhaps necessary for organising political action (Young, 1990). Woman as 'individual' has been constituted as the place where psychology and politics – psyche and citizen – become enmeshed. This individual thus becomes crucial to the construction of and theorisation of the political project of feminisms.

However, the rubric of feminism includes prolific, fractured, sometimes contradictory identities, which reflect differing concerns of women who are variously positioned and constituted within particular social and cultural contexts (Hepburn, 1999, 2000). A key point here is that the complex interweaving of gender with issues such as race and class calls into question the assumption that the category 'woman' provides a foundational grounding for fluid relations between feminists and women generally (see also Hekman, 2000).

Judith Butler (1990), amongst others, suggests that the particular basis for identification between women, the unitary subject, can work to exclude those who do not fit certain conceptualisations of what constitutes the category of 'woman'. This can be seen in early feminist work, where theorisations reflected the concerns of specific kinds of women, positioned as white, heterosexual, able-bodied and middle-class (e.g. Nicholson, 1990; Kitzinger & Wilkinson, 1997). In this way a unifying strategy may be undermined by its potential to create an excluded, subordinated other. As Dongxiao Qin (2004) points out, it is impossible for any one feminist self-theory to articulate an all-encompassing 'truth' about women as 'truth' is partial and culturally contingent. These analyses render questionable the assumption that the category of 'woman' in and of itself can provide a fixed, stable or essential relation between feminisms. 'When "identities" become pure ... the potential for diverse and democratic collectivities is threatened' (Caraway, 1992, p.1).

However, global and eco-feminists (e.g. Howell, 1997; see also Mendoza, 2002) argue that refusing to engage with 'other' feminisms, or keeping them separate, is not an alternative. This is to 'silence women' and render invisible the cultural abuses of women around the world (Hodechenedel & Mann, 2003). In emphasising the common humanity of all women, these feminists advocate the need to build international feminist links, 'in order to influence public policy makers internationally, nationally and locally to embrace the principle of "women's rights as human rights"' (Mbire-Barungi, 1999, p.435). Elahe Povey (2001) suggests that this 'could have a great impact not only on gender relations, but also on the process of democratisation and secularisation' (p.44). Proponents of this view have argued that 'by promoting discourses of difference and identity, academic feminists have disunited and castrated the feminist movement' (Hodechenedel & Mann, 2003, p.6).

Who are 'they'?

The dimensions of gender, 'race', sexuality, social class, and culture indicate that feminists *are* different (and potentially 'other') along *many* dimensions of power or powerlessness. It is extremely difficult to tease apart the power dynamics between different feminisms, and hence the processes by which 'other' feminisms are constructed.

They are 'other'

Feminists such as Carol Gilligan (1982) have argued that the recognition of difference and otherness is not only undeniable, but also desirable. Drawing on the Lacanian notion that 'the self *needs* the other in order to be a self at all' (emphasis added) (Sampson, 1993, p.153), others suggest that 'otherness' should be acknowledged and celebrated. Similarly, Iris Young (1990) problematises the assumption of necessary homogeneity, arguing that notions of unity, community and mutual identification have been deployed as alternatives to values engendered by capitalist patriarchal society. However, in attempts to accomplish this ideal, diversity between and within political groups has been suppressed and down-

played. Young suggests that from this framework, disparity in and between groups can be and has been conceptualised as a transgression of the notion of sisterhood. According to Young, this particular framework is born out of the lack of exploration of alternatives for feminist political activity. She proposes that acknowledging the presence of others need not rest on understanding another's perspective; difference should be embraced and celebrated, and diverse groups allowed political representation (see also Squires, 2001).

They are 'different'

Some feminists have criticised the process of 'othering' and the very notion of 'other'. They suggest that this notion should be replaced by the broader, and more neutral, concept of 'difference' (see, for example, Carabine, 1996), mainly because the mere fact of representing the 'other' may disempower and distort, or at least patronise and essentialise, those who are othered. This works to reinforce and reproduce the very structures of power and dominance which feminists should arguably be trying to undermine (c.f. Kitzinger and Wilkinson, 1997).

As Hannah Frith (1996) has noted, 'not all differences are equal' (p.181). This raises a number of questions. How are differences constructed and bounded? And crucially, who defines which differences matter? (c.f. Burman, 1996). Engagement with these questions might provide some insight as to why and how some feminisms come to be seen as not only different but as 'other'. These questions have practical implications. For instance, Frith (1996) has highlighted the difficulties young women have in identifying with the multiple and shifting identities of feminism (c.f. Budgeon, 2001).

Hotly debated issues within feminisms, such as concerns about pornography and the politics of heterosexuality, have served as flashpoints. In research which explored women's accounts of pornography (see Ciclitira, 1998), a participant (Wendy) voiced anger and disillusionment with feminism and its political activities. In her view, anti-porn feminism has created unnecessary categories and oppositions (including feminist/ non- feminist):

> *There's loads of meetings, pornography, let's, let's do a march, 'take back the night march', and all this crap, in bloody Tottenham, go and march in bloody Hampstead, you cheeky buggers, and throw a brick through a pornography magazine window. They really think they've done something. You know I find that amusing, and I'm being cynical there. And they call, these so called feminists, I am not a feminist, and then again what is a feminist? But they've defined it, what it's supposed to be, number one you've got to be a lesbian, number two you've got to be this, well it seems that way to me.*

In noting the difficulties that the category 'feminism' has caused her, Wendy reproduces stereotypical representations of what feminists are and do. In her view, middle-class white lesbian feminists marching in the UK against pornography and rape do not speak for a black working-class sex worker. Her own self-defined 'womanist' stance suggested a personal dilemma of feeling politically aligned to women's issues, and yet unable to accept certain perceived feminist dogmas and practices. Some black feminists gave up waiting for their experiences to be represented in mainstream feminist literature and adopted (like Wendy) a womanist approach (Wise, 1987) in which the issue of race is central (Collins, 2000; see also Boisnier, 2003).

However, multiplicity is seen as especially important in the context of feminism(s) because the factors of 'race', sexuality, social class and culture make it difficult to define what is 'same' and what is 'other', and therefore to determine boundaries within feminisms. Arguably, before we even ask ourselves which differences are most salient in the process of 'othering', we should be questioning the very notions of sameness and difference, challenging essential and exclusivist 'us'/'them' categorisations (Bulbeck, 2000), and deconstructing

absolute boundaries between 'other' feminisms. Michelle Fine and Judi Addelston (1996) have warned against explanations that use only 'sameness' and 'difference', arguing that institutional power depends on using both discourses. Indeed, the power of institutional narratives, as well as those of resistance, lies in the way they can avail themselves of manifold discourses.

Kitzinger and Wilkinson (1997) similarly argue that both denying and affirming otherness is problematic. To neglect otherness is to 'homogenise women's experience ... straining to disregard ethnic, racial, class and other distinctions' (p.11), which are possibly more salient than shared gender (see, for example, Phoenix, 1994; Chantler, Burman, Batsleer & Bashir, 2001). The differences between women are complex and not always transparent. Feminists in the West may appear to have freedom of speech, and compared to those living in non-democratic countries are able to speak out. But even a successful 'white' Westerner such as Susan Sontag (2001) became a target of fierce media criticism, death threats, and calls to have her citizenship revoked, after daring to offer a critical reading of the tragedy of 9/11.

Constructing 'other' feminisms

These issues of sameness and difference have come to the fore as both timely and politically relevant. In the current world climate, one of these differences is that between Western and non-Western cultures, with its associated religious and ideological differences – an abundance of 'otherness'. This distinction is currently at the heart of heated controversy as to whether it is possible, or even desirable, to find a common ground between Western and non-Western feminists, especially where Islamic feminism is concerned. Val Moghadam (2000) has argued that both the term and referents of 'Islamic feminism' are subjects of controversy and disagreement. In this context, as was mentioned earlier, some feminists would dismiss the idea of engaging with 'other' feminisms. For instance, Julie Burchill (2003) in *The Guardian* expressed skepticism about this particular conjunction, describing 'women claiming to find feminism in Islam' as an example of 'people who should know better searching for something (and often claiming to find it) where it never could be' (p.5).

Similar arguments have emerged around the question of whether feminism(s) are commensurable with particular religious affirmations. This is clearly evident in recent debate over the Vatican document entitled 'On the collaboration of men and women in the Church and the world'. The document calls in to question feminist(s) views on gender equality arguing that feminism(s) disrupt the 'natural' family structure of mother and father, and sets up men and women as enemies. It specifically constructs radical feminists as problematic for attempting to equalise power differentials between men and women (Owen, 2004). For some the document represents a return to religious fundamentalism and a reinforcement of traditional gender roles (e.g. 'Vatican Attacks Feminism', BBC, 2004). Whilst for others the document represents a furthering of particular feminist aims in that the document calls for the presence of women in the workplace (e.g. 'Head to Head', BBC, 2004).

These debates become increasingly complex when contextualised within relative power positionings of knowledge production in differing arenas. Shahrzad Mojab (2001) argues that Western feminist theory is in a state of crisis, since it is challenged by the continuation of patriarchal domination in the West despite legal equality between genders. She believes that it also overlooks oppressive gender relations in non-Western societies, and while rejecting Eurocentrism and racism, it endorses the fragmentation of women of the world into religious, ethnic and cultural entities with particularist agendas. In evaluating Islamic perspectives, Mojab argues that gender is a site of the exercise of power, which is unequally distrib-

uted and hierarchically organised. She concludes that patriarchy is not simply a problem of religion, nor can Islam be degenderised as if it were neutral as regards gender relations.

Fatima Mernissi (1991) and Maria Holt (1996) have argued that Islam can function as a radical and empowering ideology, particularly when contrasted to Western perspectives. They differ in that Holt sees this ideology as requiring the repudiation of specific needs by women, while Mernissi attributes this requirement to the historical imposition of Western values rather than to the development of Islam itself. For Holt, allegiance to Islam is presented as involving a voluntary abrogation of power by women. For Mernissi, it is not Islam itself that constructs difference, but the need to differentiate itself from the 'other' (i.e. the West). In this sense, the West's promotion of human rights in the Third World can be seen as a strategy for facilitating the circulation of Western goods and services (Majid, 1998).[1]

(In)conclusions

So where does this leave us in terms of 'other' feminisms? Current forms of feminisms are so varied that it is perhaps unsurprising to find so little agreement over this issue. One side of the debate claims that the heterogeneity of feminism constitutes 'a political tragedy' (Hodechenedel & Mann, 2003, p.6). The other asserts that 'the ability to deal with difference is at the centre of feminism's survival as a movement for social change' (Bulbeck, 2000, p.36) and that 'difference — in all its multiplicity — might be understood as the true energising force in feminist theory, the source of its more radical and transformative discoveries' (Johnson-Roullier, 1997, p.1188). The conflicts seem to stem, in part, from contrasting conceptualisations of 'womanhood', with one side emphasising homogeneity', 'sisterhood,' and feminist solidarity (Caraway, 1992), with the other focusing on difference, otherness and dynamics of power. We are stretched, it seems, between women's sameness and women's differences.

Nancy Fraser and Linda Nicholson (1990) contend that the solution lies in 'replacing unitary notions of woman and feminine gender identity with plural and complexly constructed conceptions of social identity' (pp.34–35). This does not mean neglecting women's or feminists' similarities, but allowing, as de Lauretis (1986) says, for a 'more inclusive feminist frame of reference' (p.14). As Lynne Segal (1999) has argued, solving the tensions and conflicts between feminisms may not always be possible, desirable, or even responsible.

Both gender and political identities become recognised, stabilised, and legitimised in manifold ways. Perhaps the real questions are when and how this 'constructing of reality' occurs. When do these identities become so resistant that they can produce political consequences? What are these consequences? Is this an interesting or useful focus for the construction of a political project? Do we need to judge feminisms as 'same', 'different' or 'other' – effectively to evaluate them 'good' or 'bad'? Might it not be more productive to trace the path of feminisms as objects in and of themselves? To ask how recognition as feminists occurs rather than to focus on whether or not it is appropriate? For example, in what way might feminisms need to be part of a global protest?

It may be more fruitful to recognise commensurabilities that exist in practice and to work with these, rather than questioning their legitimacy. Many of the worries which energised feminists in the 70s persist, but the

[1] Stephen Frosh (1997) has argued that it is fundamentalism not religion which is frightening, because of its certainty and its refusal to tolerate difference or opposition. Among the most characteristic features of fundamentalism is its gender politics, which considers women's adherence to communal values and practices as crucial. It is particularly seductive because it offers solace to lost souls. Based on omnipotent fantasies and the denial of otherness, its refusal to acknowledge the existence of legitimate controls and alternative ways of being offers release from the pain of uncertainty.

inequalities and divisions between women themselves have dramatically deepened (Segal, 2000). To avoid polarisation in political debates is not easy but can be helpful (Bulbeck, 2000). Engaging with these as recognised political forces, where relevant to and resonant with our own work, might be more productive than to try to become gatekeepers.

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Changing the story: An examination of strategies for resisting sexism(s) and racism(s)

Lisa Lazard & Lisa Marzano

The issue of social change is clearly central to discussions of oppressive systems and discourses which exist within current cultural contexts. Drawing on literature concerned with changing sexist and racist practices we reflect on the complexities of these debates. As feminist psychologists, we are particularly interested in the ways in which various strands of psychological theorising may come to embody, support and resist systems and practices of racialised and gendered oppression(s). In this paper, we discuss particular historical and contemporary efforts to subvert or deconstruct racist and sexist discourses within the context of particular theorisations of power to which specific calls for social change are aligned. Moreover, arguing from discursive and social constructionist standpoints, we consider how material and theoretical implications may be drawn out to encourage change in practice.

THIS ARTICLE IS the product of numerous discussions that we, the authors, have had about the ways in which psychology can transform, challenge and resist racism(s) and sexism(s). As feminist psychologists, we are interested in racism(s) and sexism(s) as oppressive practices through which unequal power relations are constructed and reproduced (Bhavnani & Phoenix, 1994). As Kitzinger (1991) argues 'feminism is, after all, a movement devoted to the transformation of unequal power relations (p.112). In the course of the debates that ensued between us we critically reflected on the complexities of cultural (and, therefore, political) change and on how the knowledge produced through various strands of psychological theorising embodies, supports and resists systems and practices of racialised and gendered oppression(s).

These discussions became increasing complex when contextualised within the theoretical, epistemological and ontological standpoints that we align ourselves to. For example, both the authors draw on, to varying degrees, social constructionist and discursive perspectives. However, what became apparent during the course of our discussions is that the issue of addressing 'change' from these perspectives was far from straightforward. Foster (1999) argues that strategies for resisting oppressive practices such as racism are relatively sparse within social constructionist research. Moreover, he suggests that the development of strategies for resistance or transformation of racism from some strands of this field of research have been superseded by concerns with fine-grained analyses and/or with disrupting problematical aspects of mainstream psychology. Thus a central feature of our discussions was the ways in which we could tackle the issue of changing oppressive practices from discursive and social constructionist standpoints.

In our conversations about these complex debates we identified two points of central concern. Firstly, to what extent can we, as psychologists, engage with the issue of changing gendered and/or racialised oppressions? Secondly, how can discursive and/or social constructionist perspectives contribute to the development of strategies of challenge and resistance? Our discussion of this latter point arose largely out of concerns about the extent to which discursive and/or social constructionist perspectives can be used to advocate social change

(see e.g. Parker, 1992; Doherty, Graham & Malek, 1992; Willig, 1998; Burr, 1998). Given the centrality of these issues to various strands of academic work around racism(s) and sexism(s), we found it productive to explore these multifaceted topics further through the written medium. In this article, we trace a path through the debates around the ways in which racism(s), sexism(s) and psychological 'solutions' to these issues have been constructed within psychology, with a view to interrogate the extent to which these knowledge products have supported, challenged and/or resisted these oppressive manifestations. We view 'racism' and 'sexism' as contentious, contested and multiplex terms which are highly variable and intersect with each other (e.g. Afshar & Maynard, 1994; Moghissi, 1994; Esptein, 1997). We would argue that racism(s) and sexism(s) are far from monolithic or polarised in any stable manner and we have attempted to engage with these complexities in relation to the questions we have asked ourselves.

Changing the story

Psychologists' engagement with the issue of social change is in no way new or innovative. This is evident in the words of Tiffen, Knight and Josey (1940), who claimed that 'the value of learning more about ourselves and human nature is obvious. Our social, political and economic theories rest ultimately upon our understanding of human nature. Upon sound knowledge of human nature depends the possibility of directing social changes so as to make social institutions and practices better suited to human needs. As citizens, then, we need to make our beliefs as sound and rational as possible' (pp.23–24). For psychologists, 'learning more about ourselves' and 'understanding human nature' has generally rested on the generation and accumulation of scientific knowledge of human behaviour. Thus the process of solving social problems within this tradition has primarily involved the objective and systematic documentation and elucidation of human conduct through which universal principles of human interaction can be discerned. Psychology then offered society a means through which social change could be accomplished, in that society could use these principles of human behaviour to improve itself (Gergen, 1996).

The goals of psychology and the tasks it seeks to undertake as described by Tiffen, Knight and Josey (1940) serve to construct the discipline as relatively benign in that it is concerned with human betterment. However, the question that is inevitably raised by any suggestions for human betterment is who is this better for? Psychology is abundant with knowledge products which support and maintain the oppression of particular groups whilst benefiting others (e.g. Stainton Rogers *et al.*, 1995). For example, feminist psychologists have long recognised, theorised and actively challenged the potential for harm some psychological knowledge has for women (Wilkinson, 1996; Nicolson, 2004). According to Wilkinson (1996) a common claim that has been made in psychology is that women are inferior to men. Women have often been characterised by psychology as 'inconsistent, emotionally unstable, lacking in a strong conscience or superego, weaker, 'nurturant' rather than productive, 'intuitive' rather than intelligent ... suited to the home and the family' (Weisstein 1993, p.207; see also Forbes *et al.*, 2003). These supposedly feminine attributes have long been positioned as inferior to masculine characteristics (Greene, 2004). Such psychological claims in their various manifestations can be used to validate discrimination against women. For example, Wilson (1992) argued that the reason men are more likely than women to reach the higher echelons of the professional hierarchy is because men are biologically predisposed to be competitive, and because dominance is a personality trait which is determined by male hormones. The obvious implication of such psychological findings is that women by virtue of their biology can never enjoy the same successes within the workplace as men.

Similar criticisms have been voiced in relation to psychologists' engagement (and more often dis-engagement) with issues of race, racialisation and racism(s). The race and IQ debate is perhaps the most glaring example of psychological research which has served to normalise 'whiteness' and propagate notions of black inferiority (e.g. Phoenix, 1999). Moreover, Phoenix (1999), amongst many others (e.g. Wong, 1994; Burman & Chantler, 2003) has contended that the discipline and other strands of academic work have largely failed to challenge stereotypical and essentialist constructions of racial minorities and the privileged position of 'whiteness'. Arguably, this critique does not only apply to 'traditional' or 'mainstream' approaches, but also other 'perspectives developed within a spirit of critique' (Bhavnani & Phoenix, 1994, p.11). This is evident particularly in early feminist work where the theories that were produced were often specific to and reflected the concerns of particular kinds of women such as those positioned as white, heterosexual, able-bodied and middle class (c.f. Nicholson, 1990; Kitzinger & Wilkinson, 1997; Capdevila *et al.*, 2004). Not surprisingly, many Black women and/or feminists have expressed concern that 'race' has not always been treated as an important organising principle of inequity between women within feminist theory (Bhavnani & Phoenix, 1994). According to Wilkinson (1996), psychology's perpetuation of particular forms of oppression has largely been rooted within its focus on the individual (see also Henriques *et al.*, 1998). It is to such psychological accounts of racism and sexism that our discussion now turns.

Storied solutions

Drawing on the questionable assumption of a unitary rational subject, traditional psychology locates racial prejudice and discrimination in individuals' erroneous cognitive-affective processes (e.g. Allport, 1954). For example, Tajfel's (1978) social categorisation approach constructs prejudice as the result of cognitive categorisation processes. More specifically, it is claimed that – whilst there is no 'real' difference between groups – we tend to favour those in the group that we in some way belong to over those who do not. Racial prejudice is, therefore, conceptualised as a form of out-group discrimination. It is viewed as a natural product of the cognitive mechanisms of categorisation operating within the individual (see also Brown, 1995). In short, mistaken, distorted and prejudicial judgements about a particular group are a consequence of the individual's information processing system.

Henriques *et al.* (1998) point out that the reliance on the notion of error in these accounts of prejudice holds little explanatory purchase when attempting to account for widespread phenomena such as racism and sexism because 'errors are by definition the exception rather than the rule' (p.80). Furthermore, by suggesting that racism is the result of erroneous cognitive processes for which neither the individual nor society are directly responsible, these accounts perpetuate the notion – or arguably the myth – that there are 'no real differences' between ethnic groups.

The perpetuation of the claim that no 'real' differences exist between ethnic groups may appear to be desirable in that this view appears to dissolve any 'real' basis for racism. However, such claims also fail to recognise the importance of 'race' because they effectively deny the material and representational effects that it has (Afshar & Maynard, 1994). As Henriques *et al.* (1998) argue, such claims appear to stem from 'the desire to privilege the ideal of no difference between races above the practical strategies designed to achieve it. It is the case of putting the ideal cart before the real horse, with the result that nothing moves' (p.63).

Historically, the assumption of 'sameness' has been linked with the idea that apparent racial differences are simply a product of unfamiliarity, and that these would eventually be 'assimilated' through contact and integration, or simply with the

passage of time. Racial difference has been constructed 'as something that should be dispersed across housing estates, dissolved in mixed marriage or diluted in society's melting pot' (Henriques *et al.*, 1998, pp.81–82). In the US, this idea has provided the rationale for desegregation policies in housing, employment and education, whereas in the UK it has been associated with a non-interventionist approach to issues of race and racism. Over the years, however, it has become apparent that differences do not magically disappear. As argued by Brown (2001), 'contact between groups by itself ... will not reduced and may even exacerbate prejudice' (p.512).

In spite of this, the assumption of 'no real difference' remains virtually unchallenged in social psychological accounts of prejudice. In political practice, this is reflected in current race relations and equal opportunity policies, and in the debate around employment equity. Although this may appear to be a more 'colour/gender-conscious' model of public policy, the emphasis on 'equality' of rights and opportunities functions to divert attention away from differences in power between ethnic groups and women, and, on this basis, has been accused of colour, gender (and power) evasion (see e.g. Denney, 1997). Moreover, the assumptions embedded in many of these policies are that the interests of all oppressed groups such as women and ethnic minorities are unitary, shared as well as 'progressive'. Such assumptions deny the possibility of a conflict of interests among minority groups. The consequence of this was disengagement with particular manifestations of discrimination such as white backlash and working class racism (e.g. Yuval-Davis, 1994).

Whilst this 'rationalistic denial of difference' (Henriques *et al.*, 1998) continues to underlie some social psychological accounts of prejudice, recent explanations of racism and sexism put forward within this framework have shifted away from notions of familiarity and contact, to focus on the concept of 'ignorance' (c.f. Jackson, 1992; Foster, 1999; McVeigh, 2004). Discrimination based on racial/gendered difference, in other words, is seen to be a product of individuals' ignorance. Education follows from this theorisation as a logical strategy for dealing with prejudice (for a recent discussion of anti-racist education see Manglitz, 2003; see also Thompson, 1997). By providing 'accurate' information about a particular out-group, the distorted or irrational perceptions that have been produced via categorisation – and ignorance – would be 'rationally corrected'. The assumption that it is possible to produce 'accurate' information of any one particular ethnic group can be considered problematic because such educational strategies often represent such groups as monolithic. Diversity within groups is often ignored (e.g. Afshar & Maynard, 1994). Moreover, this educational strategy clearly assumes that people will process these 'real facts' in an 'objective', unbiased way. One of the main limitations of this approach is that 'it recommends that the problem of ignorance lies with black people as the unknown object rather than with the prejudiced individual as the unknowing subject ... [thus] while blacks remain the object in focus, whites have no need to address themselves as a problem. It is in this way that social psychology has contributed to the production of blacks as the problem' (Henriques *et al.*, 1998, p.85).

Some academics have contested the very idea that mass education may offer a strategy to challenge prejudice (e.g. Thompson, 1997; Boyd & Halfond, 2000; Henze, Lucas & Scott, 1998; Herbert, 1997). From a radical standpoint, multicultural education and 'race-awareness' training have been dismissed as liberal conservative practices that divert attention away from structural and institutional power, and, in so doing, fail to address the structural oppression of women and ethnic minorities. However, it may be suggested that education *per se* is not necessarily an inadequate strategy to tackle racist and/or sexist practices. Moreover, it seems reasonable to argue that some forms

of racism, particularly towards the new racialised category of 'asylum seeker', are sustained by particular forms of information. For example, sensational media headlines, mostly in the tabloid press, have frequently employed a discourse of moral panic and national crisis, which construct asylum seekers as swamping 'our' country, raping and contaminating 'our' women, and abusing 'our' resources. Arguably, whilst racism is not merely a product of faulty information-processing mechanisms, it can be exacerbated by the circulation of specific kinds of information, or more appropriately, particular discursive constructions.

Education can serve, and has served, to circulate new or alternative constructions which can be used to resist and challenge racist and sexist discourses. The problem is not with the use of education per se as a means to tackle racisms and sexisms. This strategy, however, becomes problematic when adopted as the only 'solution' to these issues, and when the content of supposedly anti-racist or anti-sexist education serves to re-produce and legitimise victim-blaming and essentialist discourses. Moreover, as Billig (1988) points out, there is a danger that 'education may enhance the ability to produce justifications' (p.103), that is allow for more subtle, but no less oppressive, forms of racism and sexism. Nevertheless, public awareness strategies and education programmes that disseminate alternative constructions have clear potential for challenging oppressive practices.

The ways in which forms of sexism such as sexual harassment could be potentially challenged through the use of educational processes has received some attention in the literature. For example, some scholars have argued in relation to sexual harassment that training and public awareness strategies should shift the focus of education away from women and their need to manage their risk of victimisation (Carmody, 2003). This is because targeting women as recipients or potential recipients of sexual harassment serves to reinforce totalising assumptions about masculinity and femininity and, more or less directly, blames women for their powerless and victim status. As an alternative to this, anti-harassment strategies should also focus on men, and aim to change their behaviours and attitudes (Herbert, 1997). Furthermore, rather than viewing sexist expressions as individual attacks, we must educate men, as well as women, about male dominance, patriarchy and myths about male sexuality such as uncontrollable sexual urges (Ibid.). Arguably, education should also aim to encourage self-reflection and critical consciousness of power relations. As contended by Henriques *et al.* (1998) in relation to racism, 'we should not deny differences, but recognise them and analyse their cause' (p.89). When exploring the suitability and the effects of education as a strategy to challenge racism and sexism, we need to ask ourselves: who are the educators? Who is being educated? And, just as importantly, what is being taught?

Education as a strategy to challenge oppressive practices may not be problematic in itself, but has limited use when embedded in individualised, de-politicised and victim-blaming accounts of human action (Kitzinger, 1997). In such accounts of prejudice where forms of discrimination are reduced to individual errors and misunderstandings there is often the tendency for sociocultural influences on racist or sexist manifestations to be overlooked. The effect of these accounts then is that prejudicial behaviour is ascribed to a few individuals which are then pathologised and blamed for their actions whilst the rest of society is constructed as unproblematic (Thomas, 1997). This, in turn, is claimed to mask racialised and gendered inequalities, and therefore to maintain the very systems of power that produce racisms and sexisms. In the words of Millar (2004), 'to solely concentrate on prejudice is a losing strategy ... a more effective strategy in the fight against racism, is to attempt to eliminate the individual and institutional power that allows the imposition of one's racial prejudices' (p.1).

Within an individualised and de-politicised framework, relations of power operating in gendered or racialised relationships not only become constructed as more or less rare, but also become conceptualised as a property possessed by discrete individuals whereby person A exercises power via derogatory expressions over person B. This inevitably diverts attention away from the ways in which more mundane forms of power relations operate routinely in the course of everyday practices, which produce and constitute particular meanings and behaviours. As Thomas (1997) argues in relation to sexual harassment, such approaches tend to emphasise more dramatic cases of gendered violence whereas the manifestation of more routine, mundane forms remain largely untheorised and unaddressed.

These more mundane, and often more subtle, forms of discrimination are especially relevant within the current cultural context. Recent debate over silent, cultural or 'new' forms of sexism and racism has provided insight into how inequalities are produced and re-produced 'through multiple, often conflicting sets of ideas and discursive practices present(-ed) in everyday talk' (Gough, 1998, p.27). The presence of subtle and indirect forms of discrimination in mundane talk has, in turn, been theorised in different but not necessarily contradictory ways. Some critics have conceptualised these new forms of oppression as evidence that bias saturates language, culture and institution to such a degree that structural change is the only viable solution (e.g. Leach, 2002). This claim is often accompanied by calls to build political coalitions and to deconstruct systems of oppression. Therefore, the contention is that identity, solidarity and 'transversal' politics are seen as the key to challenging prejudice and discrimination (see e.g. Yuval-Davis, 1994).

Inconclusions

So where does this leave us in terms of implementing change? Our intention in this paper is not to offer a singularised solution. The psychological accounts of change in relation to racism and sexism can be viewed as storied solutions, that is, accounts amongst a manifold of different alternative perspectives (e.g. Stenner & Marshall, 1995). We would argue that to ask which one of these accounts prescribes the 'right' way in which to deal with these phenomena reduces the complexity of these issues. Therefore, we would agree with Stainton Roger's (1989) contention that 'to claim any one of these perspectives (or indeed any other) as 'correct' in any ultimate sense is an act of faith not of knowledge ... faith that is not reflected upon and which is not subject to criticism runs the risk of crossing the boundary between concern and crusade' (p.56).

To say that psychological theories and practice are implicated in the (re)production and maintenance of gendered/racialised inequalities does not presuppose that we conceptualise psychology as monolithically oppressive or that the knowledge produced in this arena can never be used to resist racist or sexist practices. For example, as mentioned earlier, psychology's investment in traditional scientific norms has aided the maintenance of racist and sexist practices. However, this does not presuppose that there are not political advantages in drawing on these theorisations. As Kitzinger (1997) points out the commitment to science within some research areas of lesbian and gay psychology has legitimised the research field as well as proving valuable in establishing lesbian and gay civil and political rights. Moreover Phoenix (1999) contends that 'some psychologists have undermined rather than reproduced racism' (p.134).

Given the complexities of the effects of psychological knowledge we would argue that power relations are not uniformly repressive and prohibitive. Rather, we would agree with Foucauldian theorisations of power as productive, that is, producing and constituting our concepts of race, gender, individuality and knowledge of the world more generally. In other words, power is not simply a phenomenon which subjugates

particular groups, but rather, promotes, constructs and cultivates particular racialised/gendered identities and relations. As Henriques *et al.* (2002) argue: 'power is invested in discourse; equally, discursive practices produce, maintain or play out power relations. But power is not one sided or monolithic, even when we can and do speak of dominance, subjugation or oppression. Power is always exercised in relation to resistance' (p.428). The question that can be raised at this point is how, as academic psychologists, can we enact forms of resistance? For Foucault (1979), there is a multiplicity of points of resistance within the power network. It follows that there is no one locus of rebellion against particular forms of power, rather there is a plurality of points where power can be challenged. For this reason we would argue that the search for a single watertight solution to these issues is too simplistic. Rather, there is a need to subject all strategies to critical scrutiny, which of course includes our own, in order to remain reflexive to the problems, costs and the warrants to power afforded by accounts whilst remaining open to the insights that these strategies have to offer (Curt, 1994).

We would argue that an important way in which manifestations of racism and sexism are made possible is by becoming discursively legitimated in personal subjectivities and sustained by local cultural conditions. This, in turn, suggests that, as psychologists, one way in which we may be able to resist racism and sexism is by exploring how discourses serve to construct meanings and oppressions, and trying to identify and challenge the discursive practices that maintain and reproduce racism and sexism. Arguably, challenging such discourses also involves strategies for disseminating viable alternatives to wider audiences. For instance, we could explore more accessible means of representing different, and perhaps more critical understandings of these issues. Furthermore, we would argue that it may be productive to continually map the effects of implemented changes and possible strategies of resistance in order to remain sufficiently open to their potentially problematic aspects. This may also afford us insight in to how those discursive formulations which reproduce and maintain racism and sexism can be challenged.

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Appendix 7. Unbound Appendix

For ease of navigation in Chapters 5 to 9, this unbound appendix provides details of all interviewees (pp. 2-5), as well as a brief description of staff roles (pp. 6-7) and transcription conventions (p. 8).

Appendix 7a. Tables 1-4: Descriptive Characteristics of Participants

Table 1. Descriptive Characteristics of Officer Participants

Officers	Grade	Gender	Age	Length of Service in the Prison Service
Ann	Officer	F	32	18 months
Bernie	Officer	M	39	15 years
Carol	Senior/Principal Officer	F	31	8 years
David	Senior/Principal Officer	M	37	13 years
Erik	Officer	M	28	1 year
Frida	Officer	F	33	3 years
Gavin	Officer	M	57	16 years
Harry	Officer	M	59	22 years
Ian	Officer	M	28	3 years
Jonathan	Senior/Principal Officer	M	43	16 years
Kevin	Officer	M	36	3 years
Luke	Officer	M	39	16 years
Matthew	Senior/Principal Officer	M	37	18 years
Norma	Officer	F	31	4 years
Olivia	Officer	F	39	12 years

Please note that one officer participant was a principal officer, and three were senior officers. This information is presented in a collapsed form, to protect participant anonymity. For the same reason, details of participants' ethnicity were not included in table 1 (or in tables 2 and 3 below). With the exception of two officers who described themselves as "Black", all others in the sample were "White".

Table 2. Descriptive Characteristics of Healthcare Staff (HC) Participants

Healthcare Staff	Gender	Age	Length of Service in HC Role	Length of Service at the Prison
Anthony	M	27	5 years	*
Catherine	F	37	20 years	10 months
Darren	M	41	9 years	1 year
Ed	M	43	20 years	7 years
Fay	F	32	7 years	2 years
Gareth	M	30	5 years	5 years
Hazel	F	44	20 years	1 year
Isabel	F	*	30 years	10 years
Jane	F	40+	22 years	6 years
Ken	M	*	10 years	2 years
Lee	M	45	20 years	5 years
Maria	F	48	15+ years	4 years
Nathan	M	37	16 years	3 and ½ years
Oscar	M	49	7 years	1 year
Peter	M	48	23 years	3 years

* Missing data

Four of the healthcare staff interviewed were general nurses, six were mental health nurses, two were substance misuse nurses, one was a substance misuse and mental health nurse, and two were doctors. Four of these were bank staff, and the remaining 11 were permanent members of staff (of which two were appointed on a part-time basis). In this case, only three interviewees were "White", one "Asian", and all others "Black". This was seemingly representative of the ethnic make up of the healthcare staff working at the prison (see Ch. 9.2.1).

Table 3. Descriptive Characteristics of Specialist Participants

Specialist Staff	Age	Gender	Length of Service in the Prison Service
Anita	32	F	5 years
Ben	*	M	*
Craig	62	M	30 years
Daniel	37	M	15 years
Enid	34	F	10 years
Frank	43	M	20 years
Gail	*	F	5 years
Hillary	55	F	21 years

* Missing data

Please note that information about each specialist's role, length of service at the prison, and ethnicity was withheld to protect participant anonymity. Interviewees in this group had worked at the research establishment from as little as two months to a maximum of eight years, and included: the Governing Governor, Safer Custody Governor and Suicide Prevention Co-ordinator at the establishment, as well as members of the prison In-Reach Team, Psychology, Chaplaincy, the Staff Care and Welfare Service and the local Care Team (please see glossary). Six of the specialists interviewed described themselves as "White", one as "Black", and one as "Asian".

Table 4. Descriptive Characteristics of Prisoner Participants (continued on the next page)

	Age	Ethnicity	Marital Status	Status	Sentence Length	Index Offence	First Sentence	Information about ACCT Status and Self-Harm History
Andrew	34	White	*	Sentenced	6 years	Wounding with intent	*	On ACCT at the time of the interview. Reported having stopped self-harming, but subsequently started to do so again.
Bill	27	White	Single	Sentenced	* (Release imminent)	Theft	No	On ACCT at the time of the interview. Singled out by various members of staff as a very "prolific self-harmer".
Carl	*	Black (Foreign National)	*	Sentenced expired Awaiting deportation	* (Release imminent)	Reported consenting sex with a minor (prison file not available)	Yes	On ACCT at the time of the interview. Suicidal intentions unclear.
Donald	26	White	Single	Sentenced	16 months	Theft	No	On ACCT at the time of the interview.
Ethan	42	White	*	Sentenced	30 months	Multiple offences against property	No	On ACCT at the time of the interview.
Fred	26	White	Single	Sentenced	16 month	Breach restraining order	No	On ACCT at the time of the interview.
George	36	White	Divorced	Remand	N/A	Wounding with intent to kill	No	History of self-harm, but no longer on ACCT at the time of the interview.
Harold	22	White	Married	Remand	N/A	Theft	No	On ACCT at the time of the interview.
Isaac	30	White	Cohabiting	Sentenced	1 year	Handling with intent to supply drugs	Yes	On ACCT at the time of the interview. Self-harmed for the first time in custody
Jack	26	White	Married	Remand	N/A	Possession with intent to supply drugs	Yes	Recent thoughts of self-harming, but no history of self-harm.
Kieran	29	White	Single	Remand	N/A	Theft	No	On ACCT at the time of the interview. Suicidal intentions unclear
Leo	36	White	Married	Recalled	N/A	Theft (whilst on licence)	No	On ACCT at the time of the interview.

Table 4 (Continued). Descriptive Characteristics of Prisoner Participants

	Age	Ethnicity	Marital Status	Status	Sentence Length	Index Offence	First Sentence	Information about ACCT Status and Self-Harm History
Mark	31	White (Foreign National)	*	Detainee	N/A	Illegal immigrant	No	On ACCT at the time of the interview.
Nick	31	Asian (Foreign National)	Cohabiting	Remand	N/A	Grievous bodily harm	No	Not on ACCT at the time of the interview. Reported history of self-harm and current thoughts of self-harming (suicidal intentions unclear).
Oliver	52	White	Single	Recalled (sentenced)	7 years 6 months	Multiple sexual offences against minors	No	On ACCT at the time of the interview.
Paul	30	White (Foreign National)	Cohabiting	Remand	N/A	Theft	*	On ACCT at the time of the interview.
Quentin	33	White	Cohabiting	Sentenced	9 months (Release imminent)	Breach of sex offender order	No	History of self-harm, but no longer on ACCT at the time of the interview.
Richard	24	White	Single	Convicted Awaiting sentence	N/A	Rape	No	On ACCT at the time of the interview.
Stephen	33	White	Single	Sentenced	30 months	Conspiracy to indecent assault	No	History of self-harm, but no longer on ACCT at the time of the interview.
Tom	37	White	*	Sentenced	4 years	*	No	On ACCT at the time of the interview.

* Missing data

Please note that all prisoner participants had been in custody for at least 6 weeks at the time of the interview.

Appendix 7b. Description of Professional Roles

(i) Officers: Uniformed staff responsible for "the security, supervision, training and rehabilitation of people committed to prison by the courts" (Grayburn, 2006, p. 1). In other words, prison officers are expected to "punish, deter, isolate and rehabilitate offenders while at the same time maintaining order and inmate productivity" (Kauffman, 1988, p. 45).

Prison officers are the largest staff group in prisons, and have the greatest degree of contact with prisoners (Bryans & Jones, 2003; see also Liebling & Price, 2001). In England and Wales there are three uniformed officer grade: prison officers (forming the largest, 'basic' grade group), senior officers (S.O.) ("who act as first line managers" (Bryans & Jones, 2003, p. 640)) and principal officers (P.O.) ("who manage units of accommodation, or tasks such as security and who line manage senior officers" (*Ibid.*)). Please note that the term "officer" is used in this thesis to refer to all three officer grades, rather than to connote (basic) grade.

(ii) Healthcare Staff: Medical staff working in prisons, including doctors and nurses.

(iii) Specialist Staff: Although there is no official or agreed definition of specialist staff, this term may be used to describe staff from different grades, disciplines and professional backgrounds, who have a specific role with prisoners and/or other staff groups. In the present study this definition was applied to those practitioners and others whose specialised role was to support self-harming prisoners and/or staff dealing with this issue. This included:

Chaplain

In England and Wales, "chaplains from a wide range of faith traditions work with the Prison Service, including Buddhist, Church of England, Free Church, Hindu, Jewish, Muslim, Roman Catholic, and Sikh" (HM Prison Service, 2004a, p.1). Their role is to "serve the needs of prisoners, staff and faith communities" (*Ibid.*).

Governors

Prison governors manage prisons and "remain ultimately responsible for everything that happens behind the [prison] walls" (Bryans & Jones, 2003, p. 643). Whilst their precise work and responsibilities vary according to the size and type of prison, their general role encompasses a number of key tasks:

> Managing the business of the prison, managing staff and prisoner and managing boundaries [...] delivering against key performance indicators and targets, financial control and management, self-audit, planning for emergencies, fostering effective public relations, maintaining order, providing constructive regimes for prisoners, developing and managing staff and dealing with disputes, outside agencies and the public. (See also Bryans, 2007; Bryans & Wilson, 2000; Walsh, 2005).

The Governor in charge of each prison is also commonly referred to as "**Governing Governor**" or "Number 1 Governor". He or she will be supported by a number of Operational Managers and Senior Managers, traditionally referred to as "Governor Grades" (see Liebling & Price, 2001). This may include a "**Safer Custody Governor**", responsible for ensuring that the prison is "a safe environment for all who live and work

there" (Safer Custody Group, 2001, p. 1).

In-Reach: As part of the national drive to deliver mental health services to prisoners (see Department of Health, 2001; Department of Health & HM Prison Service, 2002), community mental health in-reach teams are now operating in many establishments in England and Wales. Their aim is to "improve the mental health care provided to prisoners who need it and to help in providing the correct amount of appropriately trained and skilled staff" (Emslie et al., 2005, p. 17) (see also Armitage, Fitzgerald, & Cheong, 2003).

PICT Co-ordinator: Staff member responsible for co-ordinating a prison's Staff Care Team. As established by Prison Service Order 8150 (HM Prison Service, 1998, para. 1.1), "care teams are selected locally from staff volunteers, reflecting the range of disciplines within the establishment and in proportion to the size and type of establishment. Their basic tasks are:

(i) To give immediate and early practical and befriending support to colleagues following an incident at work;
(ii) To listen to colleagues in order to enable them to make sense of what has happened and their reactions to it;
(iii) To liaise with Staff Care and Welfare Service (SCWS) when colleagues request further help after incidents at work;
(iv) To provide information to colleagues of sources of help for non-incident problems (e.g. relationship problems, general stress, alcohol abuse, debt, bereavement etc)."

(See also HM Prison Service, 2003; HM Prison Service, 2004b)

Prison Psychologist: Psychologists working in prisons come from a variety of backgrounds and (sub)disciplines, including Forensic, Counselling, Organisational and Health Psychology (see Towl, 2002, 2004). Their main responsibilities include:

(i) The design, delivery and evaluation of psychological interventions to reduce prisoners' risk of re-offending;
(ii) One-to-one and group counselling (including in relation to self-harm);
(iii) Risk and clinical assessments;
(iv) Staff selection, recruitment and training.

Staff Care and Welfare Officer: Representative of the National Staff Care and Welfare Service (SCWS). Amongst other duties, a SCWS officer organises critical post-incident debriefs and refers staff for confidential and independent counselling (see HM Prison Service, 2003; HM Prison Service, 2004b).

Suicide Prevention Co-ordinator (SPC): Although Governors have overall responsibility for the implementation of suicide and self-harm prevention strategies within their establishments, much is delegated to SPCs. These support Safer Custody Governors (see above) in their duties, holding key responsibilities for the implementation and development of local policies and procedures (see e.g. HM Prison Service, 2003). Please note that SPCs may be drawn from any grade or discipline.

Appendix 7c. Transcription Notation

Throughout the thesis, direct quotations from participants are reported in double quotation marks, or as indented, single-spaced paragraphs. Participants' pseudonyms are provided when citing excerpts from their transcripts. The numbers in brackets after each interview extract refer to line numbers from the full transcript (please note that the latter are only available to the examiners of this thesis – see Ch. 2.11.1), whilst the number in brackets within excerpts denote the number of seconds of a pause (a full stop in brackets (.) indicates a brief (less than one second, but perceptible) pause). In sections dealing with one or more participant groups, the interviewee's staff group is also reported. The interviewer is indicated by the letter L. If the participant's pseudonym also starts with the letter L, the interviewer is indicated by the letters LM. Other key symbols and conventions to aid the interpretation of extracts are presented in Table 5 below (a full copy of the transcription notation is presented in appendix 5).

Table 5. Key Transcription Conventions

Words which are underlined were spoken with emphasis
Words in uppercase were uttered noticeably louder than the surrounding words
Words which could not be heard/understood during transcription are indicated by a lower case x per word
An uppercase X indicates a name of a person or place which cannot be given for the sake of confidentiality
A sigh or a loud intake of breath are indicated in the text by ..hh
An 'equals' sign at the end of a speaker's utterance indicates the absence of a discernible gap between speakers
A colon (breaking up a word) indicates an extension of the preceding vowel sound, or phoneme